AdvaNCing Equity in Aging:

A Collaborative Strategy for NC

North Carolina State Aging Plan // 2023-2027

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Aging and Adult Services

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
JOYCE MASSEY-SMITH • Director, Division of Aging and Adult Services

Verification of Intent

LETTER FROM THE SECRETARY

June 7, 2023

Dear Governor Cooper and Fellow North Carolinians:

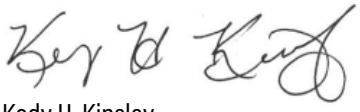
The North Carolina Department of Health and Human Services is pleased to present the 2023-2027 North Carolina State Aging Plan as required by N.C.G.S. 143B-181.1A and Section 307 of the federal Older Americans Act (42 U.S.C. § 3027). The Division of Aging and Adult Services and its many partners have spent the past year gathering comments and ideas from citizens statewide about the needs of our growing and ever changing older adult population. The Plan will help further engage and serve our older adult population and citizens over the next four years.

I am pleased that the 2023-2027 North Carolina State Aging Plan continues to build on my vision of a government that focuses on strong and inclusive workforce, child and family well-being, and behavioral health and resilience for the people of North Carolina. These priorities include supports for direct care workers in nursing facilities and home and community-based programs to stabilize the workforce and address critical gaps in caring for older North Carolinians, providing a subsidy to kinship care, and providing support for the behavioral health crisis.

To prepare for the development of this plan, the Division of Aging and Adult Services partnered with the North Carolina Association of Area Agencies on Aging, AARP NC, Hometown Strong, and other key partners and citizens to host six listening sessions. These informative sessions were held in October and November 2022, in collaboration with the Age My Way initiative. Over 350 older adults, including caregivers, service providers, business and faith community leaders, and public officials from across the state responded to our invitation to share their thoughts on the status and future of older adults. Other interested individuals from across the state participated virtually via Zoom listening sessions hosted at various senior centers and shared their challenges and hopes. In addition, between the State Aging Plan Community Survey and the Age My Way NC Survey, there were 3,793 surveys completed from older adults, adults with disabilities, caregivers, and other citizens across the state. The State Aging Plan reflects this exchange of information and the desire of the Department to lead in developing better and more effective ways for citizens of our state to age with dignity.

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

Sincerely,



Kody H. Kinsley
Secretary of NC Department of Health and Human Services

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HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
JOYCE MASSEY-SMITH • Director, Division of Aging and Adult Services

Verification of Intent

The State Plan on Aging is hereby submitted for the State of North Carolina, Department of Health and Human Services, for the period of October 1, 2023 through September 30, 2027. It includes all assurances and plans to be conducted by the Department of Health and Human Services, Division of Aging and Adult Services under provision of the Older Americans Act, as amended, during the period identified. The State Agency named above has been given the authority to develop and administer the State Plan in accordance with all requirements of the Act, and is primarily responsible for the coordination of all State activities related to the purpose of the Act i.e., the development of comprehensive and coordinated systems for the delivery of support services, including multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for the elderly in the State.

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

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

Signed _____ 6/2/23
STATE UNIT ON AGING DIRECTOR — DATE

Signed _____ 7/13/23
STATE AGENCY DIRECTOR, WHERE APPLICABLE — DATE

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

Signed _____ 7/18/2023
GOVERNOR — DATE



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I. Narrative

EXECUTIVE SUMMARY: ADVANCING EQUITY IN AGING

The North Carolina Department of Health and Human Services (NCDHHS) Division of Aging and Adult Services (DAAS) works to promote the independence and enhance the dignity of North Carolina's older adults, people with disabilities and their families by providing them with a community-based system of opportunities, services, benefits, and protections. The State Plan on Aging includes all assurances and plans to be conducted by NCDHHS DAAS under the provision of the Older Americans Act of 1965, as amended and codified through the *Supporting Older Americans Act of 2020*. As part of this process, NCDHHS DAAS is mandated to submit a multi-year plan to the Administration for Community Living (ACL), detailing goals and objectives aimed at assisting older adults, their families, and caregivers. The state agency named above has been given the authority to develop and implement the state plan in compliance with the act's requirements and is primarily responsible for coordinating all state undertakings concerning the act's purposes, such as developing comprehensive and coordinated systems for delivering supportive services, including multipurpose senior centers and nutrition services, while acting as an effective and visible advocate for older adults.

Overview:

The Plan's six goals take into consideration the multi-faceted nature of what is required to address the needs of an aging population.

The proposed Federal Fiscal Year (FFY) 2023-2027 focus areas are outlined below:

Safety, Protection, and Advocacy	Use policy, advocacy, education, and a multi-disciplinary approach to protect the rights of Older North Carolinians from abuse, neglect, and exploitation.
Healthy Aging/ Quality of Life	Support programs and partnerships that improve the health and well-being of Older North Carolinians.
Housing and Homelessness	Adopt an equity-centered housing lens approach to enable older adults to age in their place of choice with the appropriate services, supports, and housing opportunities.
Caregiving Support and Workforce Development	Advance equity, accessibility, and inclusion through informal and formal caregiving support.
Long-term Preparedness Planning	Incorporate innovative practices learned through COVID-19 and create reliable systems and infrastructures that will have the capacity to serve the growing aging population, all while recognizing the need for communication equity to foster involvement from all stakeholders.
Advancing Equity and Reframing Aging	Advance equity by supporting and encouraging older adults of all backgrounds and their support systems to access information that helps them make informed choices about support services at home or in the community.

CONTEXT

a. Demographics:

North Carolina has seen significant demographic changes in the 21st century, with a national ranking of 9th in population aged 65 and over. Thus, it is crucial to assess and understand the demographic changes and their ramifications to effectively address age-related issues, catalyze change, and prepare for the future of the state. In 2021, one in six people in North Carolina were over the age of 65. That number represents 1.8 million adults, or 17% of the total population, in North Carolina. By 2031, there will be more individuals aged 65 and over than children under 18 in the state. According to the North Carolina State Center for Health Statistics, if age-specific mortality rates remain unchanged, North Carolinians aged 65 and over can expect to live for an average of 19 more years. Some key factors reshaping and increasing North Carolina's older population include the aging Baby Boomer population, increase in average life expectancy over time, decline in fertility, and migration of people from other states and abroad. By the year 2030, all Baby Boomers will be between the ages of 66 and 84.

NC POPULATION 65+ RACE/ETHNICITY AND SOCIO-ECONOMIC DEMOGRAPHICS

78% **White:** 77% are White (not Hispanic or Latino)

17% **Black or African American**

1.5% **Asian**

0.9% **American Indian and Alaska Native**

1.4% **Two or more races**

2.3% **Hispanic or Latino**

14% **Less than high school education**

28% **Bachelor's degree or higher**

9% **Live below 100% poverty**

10% **In 100%-149% poverty level**

Census Poverty threshold 2021:

- $12,996 for an individual age 65 or older
- $16,400 a household of two people with a householder 65 years or older

18% **In labor force**

83% **Have one or more chronic conditions**

(30% of those ages 65-75 and 50% of those ages 75 and up have hearing loss.)

b. Needs Assessment:

- To develop the State Plan on Aging, DAAS undertook extensive efforts to examine how services and program delivery systems for older adults, adults with disabilities, and their families and caregivers can be improved to better meet the needs of North Carolina's aging and disability population.
- To gain a comprehensive understanding of the needs, priorities, and challenges of North Carolina's aging and disability population, the State Aging Plan Community Survey was disseminated; this survey was distributed across the state from October 2022 through March 2023 to ensure that as many people as possible had an opportunity to provide their input. The survey was designed to be inclusive and accessible to all members of the community, including older adults, adults with disabilities, caregivers, service providers, and advocacy organizations. The survey gathered information on a range of topics and was promoted through social media, listservs, newsletters, and community outreach events across the state. The response rate was impressive, with 583 individuals participating and providing valuable insights that helped shape our objectives and strategies for the 2023-2027 Aging Plan. Through the Community Survey, a broad range of perspectives from across the state was gathered, which was instrumental in guiding our efforts to improve the lives of North Carolina's aging and disability population.

- A detailed survey, Age My Way NC Survey, conducted by the AARP Research Team/Department May 1 - August 26, 2022, asked North Carolinians ages 45 plus how their communities, counties and rural areas are meeting the needs of the state's rapidly growing population of older adults. A team of community and state partners including DAAS and Hometown Strong steered the Age My Way NC survey implementation. The survey collected results from 3,209 respondents with a 1.8% margin of error. Most survey respondents were homeowners (88%) living in single family houses (81%). Information from the survey was used to identify and evaluate areas of concern when it comes to aging in the state.
- Ensuring equity through the data life cycle: In an effort to ensure that all policies and programs are grounded in data and reflective of the unique needs and challenges of all members of the community, including those who are often marginalized and underrepresented, DAAS will be undertaking steps to collect and include sexual orientation and gender identity (SOGI) data elements in data collection and program evaluation efforts.

c. Stakeholder Engagement:

- The plan reflects extensive input from the community, including people of all ages and abilities, actively considering the needs of populations facing racial and ethnic disparities.
    1. To better understand the challenges and opportunities associated with the needs of North Carolina's aging and disability population, DAAS undertook a comprehensive effort to engage with key stakeholders and identify areas where services and program delivery systems could be improved. DAAS and the North Carolina Association of Area Agencies on Aging (NC4A) co-hosted six in-person listening sessions that were attended by 350 people from diverse backgrounds across the state. These sessions took place in October and November of 2022 and were specifically designed to solicit feedback from older adults, adults with disabilities, their families and caregivers, advocacy organizations, and service providers/aging subject matter experts of all backgrounds. Additionally, one virtual statewide listening session was hosted to ensure that all interested parties had an opportunity to contribute their insights and perspectives. Through these listening sessions, critical insights were gained into the needs, concerns, and aspirations of North Carolina's aging and disability population. DAAS is confident that this comprehensive approach to engagement will help us identify and address the key issues facing this population and drive positive change for years to come.
    2. During the listening sessions, participants discussed various topics and posed critical questions to guide the conversation. These questions included the challenges that the community faces and potential solutions to those problems. Additionally, the community's strengths and assets were also highlighted, along with suggestions on how the community should grow. Participants also shared their ideas on what is needed to age in place safely and comfortably. Finally, there was a discussion on what could be done to enhance the quality of life for community members. These key questions and topics generated robust discussions and provided valuable insights into the needs and aspirations of the community.
- In collaboration with AARP NC and Hometown Strong, DAAS hosted a facilitated roundtable discussion. This event brought together over 180 subject matter experts to identify critical issues that require effective policy and programmatic responses. The Age My Way NC roundtable discussion was designed to drive discussions on key questions related to aging in North Carolina and the AARP domains of livability. Participants were asked to share their perspectives on what the domains mean to them and to identify any gaps in the current support and services available for older adults. Additionally, the roundtable discussion also focused on identifying examples of best practices and solutions that could be implemented to improve the quality of life for older adults. Finally, the discussion also centered on identifying the current and future needs of older adults in North Carolina. This facilitated roundtable discussion provided a valuable platform for subject matter experts to share their knowledge and expertise on aging-related issues and generate insights into addressing critical challenges facing the aging population in North Carolina.

- Following a careful review of key themes from the listening sessions, written comments, and the Age My Way NC facilitated discussions, an Aging Plan Committee consisting of diverse internal and external stakeholders was established to develop strategies for the 2023-2027 plan. The Aging Plan committee was also inclusive of diversity, equity, and inclusion organizations, such as partnerships with LGBTQ+ organizations, namely the Carolina Aging Alliance and SAGE USA, and Hispanic/Latinx organization, such as El Centro. This committee was formed with the goal of creating a comprehensive plan that addresses critical aging-related issues in North Carolina. To achieve this objective, the committee divided into six sub-committees, each tasked with developing objectives and strategies for their respective goal. This collaborative approach allowed for the effective utilization of the expertise and knowledge of diverse stakeholders to create a plan that is responsive to the needs and aspirations of the aging population in North Carolina.

d. Next Steps:

- This four-year plan represents a critical foundation upon which the NCDHHS will address the many challenges and opportunities that come with an aging population, including adults with disabilities. As the population continues to age, it is essential that a comprehensive plan is in place to ensure that all individuals have access to the support and resources they need to age with dignity and independence. NCDHHS is committed to this cause and will track and report progress on an annual basis. The data and insights from these reports will be reviewed with key stakeholders, and any necessary amendments will be made to ensure that we remain on track to achieve our objectives. This plan represents a significant step forward in our collective efforts to build a more inclusive, equitable, and supportive society for all North Carolinians, and DAAS is confident that it will have a profound and lasting impact on the lives of those we serve.
- Furthermore, DAAS intends to expand upon this State Aging Plan and pursue the coordinated development of a 10-year Multisector Plan for Aging to serve as the comprehensive, long-term planning blueprint for aging in North Carolina.
    - North Carolina, along with nine other states, was selected by the Center for Health Care Strategies (CHCS) in 2022 to participate in a multi-state learning collaborative to advance Multisector Plans for Aging and build upon work already underway. Participation in the learning collaborative has helped North Carolina understand how a Multisector Plan for Aging can help prepare for the challenges and opportunities of an aging state and leverage and align with current initiatives with future large-scale, cross-sectoral strategies. On May 2, 2023, Governor Roy Cooper issued Executive Order No. 280 directing action to continue the state's commitment to building an age-friendly state. The Executive Order brings a whole-of-government approach to support North Carolina's aging population. Executive Order No. 280 directs NCDHHS along with expert working groups to develop a Multisector Plan for Aging.

QUALITY MANAGEMENT

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

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

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

During the next four years, DAAS will continue to strive for excellence in quality management. The new DAAS Monitoring Plan FY23 is currently being drafted and will include updates for this fiscal year. The DAAS monitoring plan is reviewed annually to add any new guidance's or changes in policies and procedures. Each program will continue to improve monitoring tools as needed based on feedback from subrecipients and staff, as well as recommendations from the lead monitor and DAAS management. Also, an annual risk assessment meeting will be conducted every January to evaluate the level of risk for HCCBG and Non-HCCBG programs in all 16 regions.

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

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

GOALS, OBJECTIVES, AND STRATEGIES

The goals, objectives and strategies described in this section represent the mission of NCDHHS as they relate to older adults, adults with disabilities, and their caregivers. Over the next four years, NCDHHS will make advances in the areas of access to healthcare, independence of older adults, options for healthy living and aging, individual safety and rights, community collaboration, and accountability of government programs and services. The 2023-2027 plan goals focus on safety and protection, healthy aging and quality of life, caregiving support and workforce development, housing and homelessness, long-term preparedness planning, and advancing equity and reframing aging. Each goal contains objectives and strategies that will guide us over the next four years in fulfilling our mission. Also included are the plan's performance measures and expected outcomes, the culmination of the work that will be completed. The plan was created to ensure consistency with the department's mission and vision of collaboration with our partners to provide essential services that improve the health, safety and well-being of all North Carolinians, as well as advancing innovative solutions that foster independence, improve health and promote the well-being of its people. The department priorities, strong and inclusive workforce, child and family well-being, and behavioral health and resilience, were also integrated in the plan. The goals presented here are the result of a collaboration that included input from North Carolinians, service participants, stakeholders, DAAS staff, NCDHHS division staff, AAA staff, and other subject matter experts. Six in-person listening sessions and one virtual statewide listening session were held across the state, and two surveys were distributed: State Aging Plan Community Survey and Age My Way NC Survey. Advocacy organizations, such as the Governor's Advisory Council on Aging (GAC), the North Carolina Coalition on Aging (NCCOA), AARP NC, the Senior Tar Heel Legislature (STHL), the AAAs and others also participated. These goals are representative of that work.

Safety, Protection, and Advocacy:

GOAL 1: Use policy, advocacy, education, and a multi-disciplinary approach to protect the rights of Older North Carolinians from abuse, neglect, and exploitation.

In the state fiscal year 2021-2022 there were 34,470 reports alleging the abuse, neglect, or exploitation of the most vulnerable adults received by County Departments of Social Services (DSS) and the most common form of mistreatment was neglect, while 67% involved self-neglect.

The mission of Adult Protective Services (APS) in NC, a critical and multifaceted service, is to keep North Carolina's most vulnerable adults safe from various forms of maltreatment, that may present as abuse, neglect, and/or exploitation. APS is diverse by nature and works with people of varying cultural, ethnic, religious, disability and economic backgrounds. At its core, APS shall preserve the rights of the adult to make choices, therefore consideration of that ethical responsibility is essential. County DSS receive and evaluate reports of abuse, neglect, and exploitation to determine whether older adults and adults with disabilities are in need of protective services and what services are needed, as required by NC General Statute 108A, Article 6.

COUNTY SUPPORT:

(DAAS) uses Continuous Quality Improvement (CQI) to establish a collaborative process that assesses, monitors, and evaluates practice to determine the effectiveness of the agency in meeting the needs of our vulnerable adults and to drive systematic change for improvement. DAAS has created a CQI tool to capture and share quantitative and qualitative information with counties on a quarterly basis. The CQI tool continues to be updated annually to ensure ongoing assessment of needs relevant to vulnerable adults in NC. Each month DAAS hosts a Statewide Consultation for all 100 county DSS. Attendance routinely exceeds 550 DSS team members who join together virtually to hear presentations related to data trends and programmatic updates. In addition, during this time counties participate in micro-learning training experiences and hear presentations by both stakeholders and local DSS agencies to promote the sharing of resources and best practices in NC. Following the Statewide Consultation, counties receive more individualized support by attending their region's cluster meeting. Cluster meetings are facilitated by different county DSS staff and focus on specific topics of interest. The Statewide Consultations are recorded and placed on the DAAS Special Assistance - Adult Services (SA-AS) SharePoint site for county staff members who are unable to attend.

The SA-AS SharePoint site is a hub for all Adult Services information, including data, manuals, forms, and training that DAAS continuously maintains for the sharing of up-to-date and timely information with county DSS. DAAS will continue to update the majority of our Adult Services manuals to a user-friendly format that provides the foundations of statute and

administrative code, as well as guidance and practical applications for policy. DAAS will also continue provision of training on Adult Services policy through the consolidated Learning Management System (LMS) that debuted in FY21/22. The intent of the LMS is to have accessible, comprehensive, and inclusive training available on one platform. This will include virtual and in-person options and tiered level courses. In the future, training will be offered to DAAS stakeholders from multiple disciplines.

Another initiative to support county DSS is a plan to modernize the Adult Services data systems. Reliable data is crucial when it comes to providing services to clients, evidence-based practice, and obtaining funding to improve programs. Current data systems at DAAS have not been updated in decades and do not include modern reporting features. DAAS' plan is to create a modernization system that will be easy to navigate, reduce manual processes, provide adequate alerts, and allow for both communication and transparency across counties in the State.

PURSUIT OF CRITICAL FUNDING:

DAAS seeks to protect the rights of all vulnerable adults in North Carolina by preventing abuse, neglect, and exploitation. In addition to county support and data collection as detailed above, the prevention of maltreatment relies heavily on the availability of funding to support acquisition of services for vulnerable adults and fund social work positions to provide critical case management services.

Medicaid Administrative Claiming (MAC) is a funding source that has been historically underutilized. In FY 20/21 MAC funding utilization totaled $4,991,557.12. This was approximately 54% less than the $9,274,040.00 budget, which left over four million dollars unused.[1] This is especially concerning when noting that in the same fiscal year, counties reported lack of resources and funding as primary barriers encountered during the APS process.[2] After conducting an investigative inquiry into the matter, DAAS implemented a multi-disciplinary approach by entering into an interdepartmental memorandum of agreement with the Division of Health Benefits (DHB) in June 2021 to expand MAC funding to include activities associated with APS. In FY 21/22 MAC Funding utilization increased to a total of $10,544,123.78, with over five million more dollars secured from MAC funding in FY 21/22. This represented a 47% increase.[3]

In FY 22/23 the Special Assistance In-Home (SA/IH) program was expanded by legislation to make this program more readily available to vulnerable adults in need. The SA/IH program provides funding for disabled adults who are eligible for placement to age in place in their home environments with financial and case management supports. As of June 2022, there were a total of 3,747 adults receiving SA/IH services. The SA/IH program prevents unnecessary hospitalizations and placements for disabled adults.

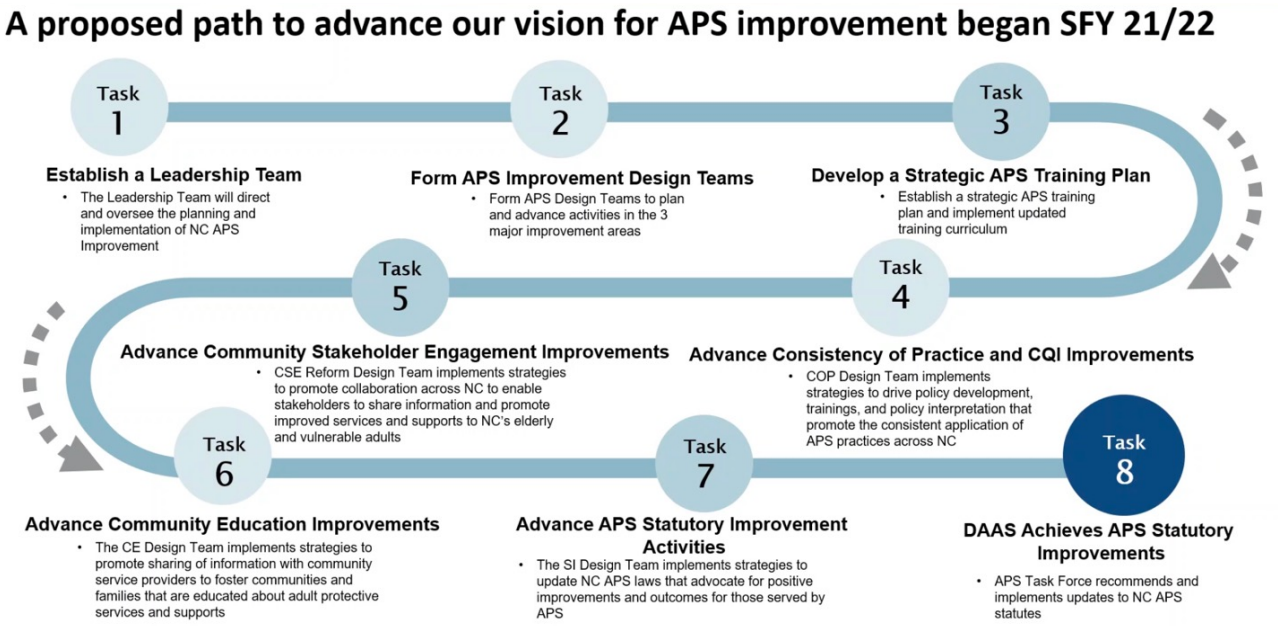
In addition to exploring maximization of MAC funding utilization, over the next four years DAAS will continue to pursue grant funding opportunities that will support the mission of preventing maltreatment of disabled adults and ensuring protections for vulnerable adults who have experienced maltreatment. In FY 21-23, two funding allocations totaling $2,028,699 were made available to county DSS to provide essential services for disabled adults who were found to be maltreated and in need of protection.[4] This funding supported provision of services to disabled adults such as home cleaning, pest control services, procurement of needed medications, in-home aide services, and assistance with housing/shelter.

MULTIDISCIPLINARY TEAMS (MDTS):

An Adult Services MDT is a group of individuals with different functional expertise working toward a common goal. These teams work together toward common goals related to Adult Protective Services, Guardianship, and other Adult Services areas. Adult Services MDTs are in various stages of development across North Carolina. Some counties have fully functioning MDTs which include community partners. These partners may include medical professionals, law enforcement, mental health services, medical providers, senior centers, and other community partners. While many counties want to re-invigorate their efforts, others are just beginning to organize groups to brainstorm what MDTs can and would look like in their county. DAAS promotes collaboration within counties and across counties to enable stakeholders to share information and promote improved services and support to elderly and vulnerable adults. The goal of DAAS is to implement MDTs to increase stakeholder engagement in all 100 counties. The North Carolina School of Government, in partnership with DAAS and county DSS, looks to develop and implement MDT procedures and practices across the state to ensure adults are protected and their needs met. In these efforts, the goal is that there will be a collaboration to provide effective service delivery and a reduction of duplication of services.

Source References: [1] FY20/21 MAC Data • [2] FY20/21 Annual Survey • [3] FY21/22 MAC Data • [4] FY21/22 Annual Survey

APS PROGRAM IMPROVEMENT[5]



One of the ways DAAS will accomplish the previously mentioned continuity in support and development in innovations in APS is through the APS Program Improvement Plan, which is a partnership project with DAAS, Public Knowledge, APS Stakeholders, and county DSS. This partnership established design teams in January 2023, and will encompass the next three years with three different workgroups covering the following areas:

- APS Statutory Reform: This workgroup is seeking to implement a task force to study and facilitate APS statutory improvement. The task force will advise on legislative and non-legislative aspects of APS including budget considerations. It will also consider statutory amendments in the legislative session to update NC APS laws that advocate for positive improvements and outcomes for those served by APS.
- Community Stakeholder Engagement and Education: In collaboration with County DSS and Area Agencies on Aging (AAA), this task force will develop and provide training to service providers and other stakeholders. Work will also focus on developing strategies to educate citizens statewide on issues of adult maltreatment. Another focus of this workgroup is implementation of MDTs for all county DSS in partnership with the University of North Carolina School of Government (UNC SOG). Quarterly community forums are planned to engage citizens in elder abuse awareness.
- Consistency of Practice and CQI: This workgroup will establish staffing and training standards, along with requirements for standardized APS tools and specialized training. This workgroup will also research and review state and national best practice models and establish and engage in comprehensive continuous quality improvement processes. These efforts will help drive policy development, training, and policy interpretation that promotes the consistent practice of APS across the state.

Along with protection from maltreatment, we must also ensure that the basic civil and human rights of older adults and adults with disabilities are protected. Adults residing in long-term care facilities and adults under guardianship often have their basic rights violated. Much work needs to be done to address the issue of civil and human rights within the long-term care setting, both in-home and at the facility level. For instance, long-term care residential settings have a Residents' Bill of Rights. In many cases, however, residents are not aware of this protection. DAAS will continue working with stakeholders and the Division of Health Service Regulation (DHSR) to ensure the Residents' Bill of Rights is made available to individuals in long-term care settings and their families.

In addition, older adults that have hearing loss (Deaf, Hard of Hearing and DeafBlind), need to receive access to clear and effective communication. Without being given the opportunity to communicate effectively, older adults with hearing loss are at risk of not being able to make informed choices. The Americans With Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 and Section 1557 of the Patient Protection and Affordable Care Act, are Civil Rights Laws protecting people with disabilities.

Source References: [5] APS Program Improvement Report

Adult guardianship is designed to support and protect the rights of individuals who are not able to make or communicate decisions about their daily life, health care and finances. In North Carolina, disinterested public agent guardians and corporations are appointed to serve as guardian when there is no other family or individual available or appropriate to serve. NC statute states that directors of County DSS are the only disinterested public agents who can serve as guardians.

The Long-Term Care Ombudsman Program promotes and protects the health, safety, welfare and rights of individuals (residents) living in long-term care facilities (nursing homes, residential care communities, including assisted living and similar settings.) The Older Americans Act and corresponding regulation directs the Ombudsman and the representatives of the Office to conduct a variety of activities in support of residents. To fulfill the Older Americans Act requirement for the Office of Long-Term Care Ombudsman Programs (within the ACL Living) to establish standards applicable to the training required for representatives of the Office of Ombudsman (representatives) in each state, the state Ombudsmen, Ombudsman program representatives, and other stakeholders worked to solidify the Long-Term Care Ombudsman Program Training Standards. The training standards intend to support flexibility while acknowledging the importance of field visits, and interactive training, either in person or by technology. Recognizing the complexity of the work of representatives of the Office, the minimum durational requirements for training will provide a solid foundation, with reinforcement through continuing education to support a successful experience for the learner and for the residents that they will serve. Amidst the increasing number of adults under public and private guardianship, and a growing state and national call for a review of how guardianship is mandated, to fulfill the recent mandate, the Ombudsman and the representatives of the Office must have subject matter knowledge of resident rights, facility regulatory standards, the resident experience, complaint investigation and the Ombudsman program's policies and procedures. They also need to know how to operationalize this knowledge; for instance, how to carry out the program polices on complaint handling procedures, how to access resident records and steps to disclose resident information. Residents call on Ombudsman programs to resolve a variety of problems; often times to address basic quality of life concerns and complex matters of eviction or abuse and neglect, therefore a baseline competency of both knowledge and skills is necessary to support effective and credible Ombudsman program services.

Furthermore, in effort to combat fraud in elder abuse and in long-term care settings especially as it pertains to provider fraud, there's on-going effort to improve collaboration and flow of information between the Ombudsmen, Office of Inspector General and Department of Justice, and the Medicaid Fraud Control Units. Additionally, as an effort to reduce elder abuse in long-term care facilities, there is the on-going effort to improve collaboration between the Ombudsman and Protection and Advocacy agencies (P and A) in all the states. In NC, the Ombudsman works closely with our P and A which is Disability Rights of NC.

ADVOCACY:

The Senior Tar Heel Legislature (STHL) and Governor's Advisory Council on Aging (GAC) are two separate but related organizations in North Carolina that advocate for the needs and concerns of older adults in the state. The STHL is composed of delegates who are appointed by the Area Agencies on Aging in each of North Carolina's 100 counties, while the GAC is appointed by the Governor to provide advice and recommendations on policies and programs that affect older adults. Both organizations work to identify and address issues facing seniors, such as healthcare, housing, transportation, and financial security, and to promote legislation that supports their well-being. The STHL and GAC serve as important voices for North Carolina's aging population and work to ensure that their concerns are heard and addressed by policymakers at the local, state, and federal levels.

The STHL has five legislative priorities for the 2023 Session of the General Assembly:

NC SENIOR TAR HEEL LEGISLATURE

Supported by NCDHHS DAAS

2023-24 LEGISLATIVE PRIORITIES

The NC Senior Tar Heel Legislature recommends these priorities to the NC General Assembly.

Visit www.ncseniorlegislature.org for more information.

#1 Allocate an additional $8M in recurring funds for Adult Protective Services (APS) to address staff shortages.

In SFY 21, APS received 32,075 reports across the state, compared to 14,001 reports in SFY 2005-2006, reflecting an increase of 129% in 17 years.

#2 Increase the Senior Center General Purpose appropriation by $1,265,316 in recurring funds.

Senior Center General Purpose funding is currently $1,265,316, which is not meeting the demands of a growing older adult population.

#3 Allocate an additional $8M in recurring funds for the Home and Community Care Block Grant.

The Home and Community Care Block Grant is the primary funding source for community-based programs that support people ages 60 and older and current funding is insufficient to meet the need. The current state appropriation is $36.9M.

#4 Allocate an additional $1.5M in recurring funds for 11 additional long-term are ombudsmen.

Ombudsmen serve as advocates for residents in nursing homes and assisted living facilities, providing protections for vulnerable elders. The current state appropriation for this program is $918.8K.

#5 Strengthen long-term care staffing standards.

In nursing homes, NC mandates minimum staffing standards for RNs and LPNs. For Certified Nursing Assistants (CNAs), there are no staffing standards, resulting in a strong likelihood of substandard care of frail elders.

These recommendations totaling $18.75M will provide supportive services and protection for the state's 2.4 million older adults.

Data provided by the NCDHHS Division of Aging and Adult Services
2022-12

The GAC's recommendations for the 2023 Session of the General Assembly:

- **Increase funding for Home and Community Care Block Grant provider agencies** to integrate core programs with population health initiatives and interact directly with healthcare systems.
- **Convene a Senior Hunger Summit** to develop a vision and strategic steps to further integrate and improve access to enhanced nutrition for older adults in need. Estimated budget: $8000 from DAAS supplemental pandemic funds.
- **Increase funding for Adult Protective Services (APS) staff**, so county departments of social services can reduce case backlogs and employee burnout. Estimated allocation: $8 million in new, recurring State funds.
- **Maintain the APS Essential Services Fund (ESF)** to provide vulnerable older adults with food, housing, medications/medical care, and other basic needs. Convert time limited ESF funding to recurring state funding with a 10% match from county departments of social services. Estimated cost: $1.5 million.
- **Update the state's outdated APS statutes** to improve service, consistency of practice, and community stakeholder engagement and education. No new funding required.
- **Address hearing loss in long-term care facilities** by funding formal, structured screening, evaluation and treatment and by educating staff regarding working with residents with deafness/hearing loss.
- **Address digital equity for older adults** by funding a statewide initiative engaging partners such as the NC Department of Information Technology's Division of Broadband and Digital Equity, DHHS's Division of Aging and Adult Services, the Area Agencies on Aging and NC State Extension. *Update: since this report was finalized DAAS was awarded $1.12 million to address digital equity.*
- **Expand the number of PACE Programs** (Program of All-Inclusive Care for the Elderly) and increase capacity of existing PACE programs with additional funding.
- **Integrate health and human services organizations in a value-based payment system**, using Healthy Opportunities pilot programs as a model.
- **Address the long-term care (LTC) workforce crisis** through efforts such as retaining enhanced Medicaid pandemic rates, loan forgiveness and grant programs for LTC nurses and other direct care staff; measures to recruit, train and retain health sciences educators who prepare students for LTC careers, incentives to retain LTC staff such as childcare vouchers and family leave provisions; targeted recruiting immigrants; studying and amending state policies and regulations that inhibit LTC staff recruitment, training and retention.
- **Strengthen and expand options for older people in need of care** by enhancing Medicaid in-home coverage, expanding the PACE program, developing a Medicaid palliative care policy, and ensuring the Medicaid Estate Recovery Program criteria don't unnecessarily restrict Medicaid eligible individuals from seeking care.

OBJECTIVE 1.1: Training and outreach regarding the protection of vulnerable older adults and indicators of maltreatment and guardianship resources will be provided to community stakeholders.

- **Strategy 1:** Partner with stakeholders in the development of training and informational materials targeted to older adults, people with disabilities, and their caregivers.
- **Strategy 2:** Improve training opportunities for the aging and adult services workforce by engaging with entities such as the University of North Carolina (UNC) Cares at the School of Social Work at Chapel Hill, to evaluate NC's existing workforce training curriculum.
- **Strategy 3:** In collaboration with The Division of Social Services (DSS) Adult Protective Services (APS) systems, share data with law enforcement and others who have contact with individuals found to be self-neglecting.
- **Strategy 4:** Develop a financial exploitation training for NC District Attorneys and law enforcement and invite DSS county staff to participate in District Attorney-led trainings.
- **Strategy 5:** In partnership with DIT, create a database for Adult Protective Services Register (APS-R) and Disinterested Public Agent Guardians (DPAG) systems to work toward standardization of the program and modernization of service delivery standards and reporting mechanism.
- **Strategy 6:** In partnership with county DSS and APS Improvement Design Team, develop communication plans for educating the public on abuse, neglect, and exploitation.
- **Strategy 7:** In partnership with the UNC School of Social Work, develop LGBTQ+ and HIV + inclusive client rights and responsibilities to be issued to recipients of care in all settings and made publicly available online.
- **Strategy 8:** In collaboration with Division of Services for Deaf and Hard of Hearing (DSDHH), provide training on working with Deaf, Hard of Hearing, and DeafBlind older adults.

OBJECTIVE 1.2: Advocate for the advancement of Adult Protective Services (APS) transformation work in partnership with county DSS and key program stakeholders to advance innovative solutions that foster and promote safety, independence, and the improvement of health and well-being for vulnerable adults served by APS.

- **Strategy 1:** Implement APS Improvement Plan through the establishment of the three design team workgroups.

OBJECTIVE 1.3: Through training and outreach, long-term care residents and those who care for and support those residents will understand and be better equipped to assist and empower their rights through training and outreach.

- **Strategy 1:** Through written communication, provide encouragement on the inclusion of the Residents' Bill of Rights in the admissions documents given to residents and/or their legal representatives.
- **Strategy 2:** Facilitate resident's rights trainings in community forums and long-term care settings and offer new educational trainings to residents/families on long-term care services to increase awareness of Ombudsman program.
- **Strategy 3:** The legal services developer will continue building and fostering partnerships with legal service providers throughout the state to ensure underserved and underrepresented communities have access to information enabling them to make informed decisions.
    - **Sub-strategy 3:** Provide training to NC residents regarding legal rights as it relates to the priority legal services.
- **Strategy 4:** Continue support of the Rethinking Guardianship Initiative to improve NC's system of rights and protections for individuals who need support and assistance with decision-making.
- **Strategy 5:** Implement work from Strategic Alliances for Elders in Long-Term Care (SAFE in LTC) taskforce, Investigating Crimes in Long-term Care Facilities: Voiceless Victims Curriculum, to strengthen the relationship between law enforcement and aging professionals.
- **Strategy 6:** Enhance standards for Community Advisory Council (CAC) volunteers through new Administration for Community Living (ACL) Training standards.
- **Strategy 7:** Continue working with appropriate regulatory agencies and referring individuals to such agencies when resolutions of concerns or grievances are not possible through the Long-Term Care Ombudsman Program.
- **Strategy 8:** Collaborate with DSDHH to provide training to ombudsman to improve their ability to serve the Deaf, Hard of Hearing, and DeafBlind aging community. Partner with DSDHH to provide training to residents and caregivers to improve their self-advocacy skills, knowledge of communication access rights and where they can find additional assistance and resources.

- **Strategy 9:** Provide training on LGBTQ+ and HIV+ rights and protections to aging service providers and staff of long-term care facilities in partnership with the State Long Term Care Ombudsman Program, Legal Assistance providers, and LGBTQ+ and HIV+ organizations.
- **Strategy 10:** DAAS will sustain relationship with transitions coordinators and support the Transition to Community Initiative to ensure those in LTC residences are aware of, and have access to, independent living options in the community.

OBJECTIVE 1.4: Through building and maintaining strong relationships with key stakeholders and advocacy organizations, advance advocacy efforts and increase awareness and support for policies and programs that promote healthy aging.

- **Strategy 1:** Establish robust quality assurance mechanisms into P and A monitoring and continue to collaborate with AAAs to strengthen recruitment efforts.
- **Strategy 2:** Provide advocacy groups, such as the STHL and GAC, with timely and relevant information, training, and continuing education regarding pertinent aging issues, empowering them to stay abreast of developments and enabling them to advocate more effectively.

Healthy Aging and Quality of Life:

GOAL 2: Support programs and partnerships that improve the health and well-being of older North Carolinians.

Older adults who practice healthy behaviors and engage in promotion and disease prevention activities are more likely to remain healthy, live independently, incur fewer health-related costs and continue to engage with family and friends. Opportunities for older adults to have access to employment, health, personal growth and social engagement are critical for the successful aging of older adults and to strengthen our communities. North Carolina will continue to build adequate and quality services and supports through the long-term care continuum and provide consumers choice and flexibility.

NUTRITION:

Nutrition security is a vital component of whole-person health. When older adults have nutrition security, food and beverages that promote well-being, prevent disease, and even treat disease are accessible, available, and affordable to them. However, too many older adults in North Carolina do not have this. Instead, they experience food insecurity, which can both cause and result from poor health, malnutrition, and/or physical or cognitive impairments. Thus, nutrition security and older adult health must be addressed together.

Over the next four years, in alignment with the NCDHHS State Action Plan for Nutrition Security, DAAS will work to ameliorate food insecurity among older adults and improve older adults' health by focusing on connecting the Senior Nutrition Programs with other health care and nutrition supports. By doing so, we hope to address older adults' food security needs, improve health outcomes, and reduce healthcare spending. We will also work to expand the reach of these nutrition programs and supports to more older adults.

This work is urgent as North Carolina's older adult population grows and continues to grapple with the impact of the COVID-19 pandemic. The pandemic worsened social isolation and deepened health disparities. Thus, the nutrition and social benefits of the Senior Nutrition Program are more important than ever. The Senior Nutrition Program is truly "more than a meal," providing valuable opportunities for social engagement and referrals for health care and social service needs. Further, for

decades, congregate and home-delivered meals programs have built trusting relationships with the older adults in their communities. Partnerships between these programs and other social and health care supports are ideal ways to help older adults get the nutrition they need, manage chronic diseases, stay connected, and maintain their health and independence.

TRANSPORTATION:

Access to transportation is a critical issue for older adults, particularly those living in rural areas of North Carolina. According to the North Carolina Department of Transportation, around 600,000 North Carolinians aged 65 and older live in rural areas, where access to transportation options is limited. Many older adults in rural areas have difficulty accessing medical appointments, grocery stores, and other essential services due to the lack of public transportation and other mobility options.

With the aging of North Carolina's population, the state Department of Transportation is increasing its focus on safe and equitable mobility/transportation. With the increasing life expectancy, the safe driving capacity of older adults may expand by up to 10 years. Nevertheless, they still require access to efficient, dependable, and affordable modes of transportation. Innovative technologies such as on-demand public transportation and Mobility-as-a-Service (MaaS) show potential in tackling this issue. The DIT NC Moves 2050 plan works to accelerate demand response and flexible multimodal strategies to meet the needs of an aging population. While there are several transportation programs and initiatives, more work is needed to address the transportation needs of older adults in North Carolina, particularly in rural areas where the need is greatest.

EVIDENCE-BASED HEALTH PROMOTION:

In partnership with UNC Asheville, NC Center for Health and Wellness (NCCHW), DAAS has been developing a centralized resource center for falls prevention and chronic disease self-management education (CDSME) resources. The NCCHW's Healthy Aging NC initiative is focused on promoting healthy aging and enhancing the quality of life for older adults in North Carolina and serves as the statewide resource center for evidence-based health promotion programs. As such, Healthy Aging NC supports a variety of programs and initiatives through maintaining a website for program information and registration, providing technical assistance and leader training opportunities, managing data collection and reporting, and developing innovative resources to support connecting people to programs. The initiative also partners with statewide coalitions, community organizations and senior centers to support healthy aging initiatives throughout the state.

FALLS PREVENTION:

The NC Falls Prevention Coalition (NCFPC) is a collaboration of organizations and individuals committed to reducing falls and fall-related injuries among older adults in North Carolina. The coalition aims to increase awareness of falls prevention strategies, promote evidence-based and evidence-informed interventions, and improve access to falls prevention programs and resources throughout the state. The coalition's activities include providing falls prevention training and education for healthcare professionals and caregivers, promoting community-based falls prevention programs, and advocating for policies and practices that support falls prevention. By working collaboratively, the coalition seeks to reduce falls and fall-related injuries and promote healthy aging for older adults in North Carolina. In the next four years, the coalition hopes to further explore the connection between falls and traumatic brain injuries. Traumatic brain injury (TBI) is a potential consequence of falls, particularly in older adults. Falls are a leading cause of TBI, accounting for around 46% of all TBIs in the United States. Falls can result in a range of TBIs, from mild concussions to more severe injuries such as skull fractures, bleeding in the brain, or damage to the brain tissue. Older adults are at increased risk of falls due to a variety of factors, including balance and gait issues, medication side effects, and vision impairments. Therefore, falls prevention programs that address these risk factors can also contribute to the prevention of TBI. According to the DPH Injury Violence and Prevention Branch (IVPB), falls are the leading cause of traumatic brain injury (TBI) among North Carolina residents aged 65 and older. In 2019, there were 7,875 hospitalizations and emergency department visits for fall-related TBIs in North Carolina. Falls were also responsible for 70% of all unintentional injury deaths among North Carolina residents aged 65 and older in 2019. These statistics highlight the importance of falls prevention efforts in North Carolina, particularly among older adults, to reduce the incidence of TBI and its associated health consequences.

ADDRESSING HEARING LOSS:

Hearing loss impacts older adults in disproportionate ways. Over 1.2 million adult North Carolinian's have hearing loss with 30% of those ages 65-75 and 50% of those over the age of 75. After heart disease and arthritis, hearing loss is the third most chronic treatable health condition and affects healthy aging and quality of life for about 532,000 North Carolinians aged 65 and over. Proper attention for hearing loss and the provision of effective communication would help to ensure success in addressing arthritis and heart disease.

Untreated hearing loss and comorbidities include a 50% increased risk of dementia, 300% increase in falling for those with mild hearing loss, and increased risk of depression and isolation. Older adults that have diabetes have a higher prevalence of hearing loss and hearing loss has appeared in 80% of those who have suffered from cardiovascular disease. People with hearing loss have significantly higher medical costs. DAAS will collaborate with DSDHH on addressing hearing loss in older adults. Hearing aids, other technology, education, and resources create opportunities for older adults to access communication that they have been missing.

SENIOR CENTERS:

Today's senior centers are community focal points for active older adults to connect with vital community services that can help them stay healthy and independent. They offer some of the most widely used services sought by North Carolina's adults ages 50 and up. Senior centers play an important role in promoting the domains of wellness among older adults, including physical wellness through exercise programs, mental wellness through cognitive stimulation activities, emotional wellness through support groups and counseling services, social wellness through opportunities to connect and interact with others, and spiritual wellness through meditation and mindfulness practices. During the COVID-19 pandemic, senior centers implemented innovative programs to support older adults while adhering to safety guidelines, such as virtual exercise classes, online mental health counseling, meal delivery services, and technology training to help seniors stay connected with loved ones. These programs have been crucial in addressing the unique needs and challenges faced by older adults during the pandemic.

SOCIAL ISOLATION:

Social isolation among older adults in NC is a growing concern, with many older adults experiencing loneliness, lack of social connections, and decreased quality of life, which can have negative impacts on their physical and mental health. Being socially isolated can have a considerable detrimental effect on a person's mortality, which is equivalent to the negative effects of smoking, being overweight, and not engaging in physical activity. The negative impact of social isolation can be compared to that of smoking 15 cigarettes a day. Loneliness, which refers to the feeling of being isolated, has been linked to various adverse health outcomes, such as a higher risk of clinical depression, anxiety, and suicidal thoughts.

In 2020, DAAS collaborated with two university researchers, Dr. Matthew Fullen from Virginia Tech and Dr. Laura Shannonhouse from Georgia State University, who specialize in examining the connection between social isolation, loneliness, and increased suicide risk among older adults. They conducted a statewide survey to explore the experiences of service providers in addressing loneliness due to social isolation, mental health issues, and elevated suicide risk. The survey revealed that the magnitude of the issues faced by older adults in their communities was much higher than service providers' capacity to address them.

In July and August of 2022, DAAS partnered with Fullen and Shannonhouse again to tackle the capacity issue identified in the previous survey. They provided a two-part training program, based on the B.E. With (Belonging and Empathy With Intentional Targeted Helping) approach, to 67 individuals across the state. The first part involved a new virtual program, developed with funding from the Administration on Community Living, that emphasized the importance of belongingness, the risk of thwarted belongingness for suicide, and how even one meaningful connection can foster a sense of belonging. The aim of B.E. With was to cultivate empathy skills, which could then enable staff to help individuals feel that they belong. Part two comprised the Applied Suicide Intervention Skills Training (ASIST), a 14-hour standardized suicide first-aid training that is included in the Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based intervention registry and used in crisis centers across the country. The effectiveness of ASIST training on aging-service professionals was evaluated by the researchers, who observed enhancements in three critical domains: comfort, competence, and confidence in intervening with an individual at risk of suicide. Furthermore, participants exhibited statistically significant progress in their level of skill.

In 2023, DAAS intends to prioritize two main initiatives: 1. To further promote social connectivity by broadening the collaboration with NCCHW and HANC to enhance their social engagement web resources and address the issue of digital equity, and 2. To expand and sustain a caregiver initiative.

HEALTHY AGING TASK FORCE:

Additionally, The NC Institute of Medicine (NCIOM), in partnership with the NCDHHS: DAAS and DPH, The Duke Endowment, and AARP NC convened a task force to focus on policies and practices that support healthy aging. The task force focused discussions to produce recommendations specifically on these four areas of need related to aging in the community setting: Falls Prevention; Mobility; Nutrition and Food Security; and Social Connections.

OBJECTIVE 2.1: Through an interdisciplinary approach, DHHS and community partners will employ system and community level strategies to meet the food and nutrition security needs of older adults, increase their access to nutritious foods, and promote healthy eating habits.

- **Strategy 1:** Collaborate with key stakeholders in NCDHHS to build connections between the Senior Nutrition Program and other NCDHHS nutrition security supports, including Food and Nutrition Services (FNS), NC Medicaid and the Healthy Opportunities Pilots, NCCARE360, and others.
- **Strategy 2:** Collaborate with regional Area Agencies on Aging (AAAs) to encourage local community service providers to join NCDHHS' FNS benefits marketing campaign by sharing best practices about FNS benefits outreach and messaging.
- **Strategy 3:** Enhance the capacity of local community service providers to connect at-risk older adults with food benefits programs by conducting outreach and arranging educational programs to teach their seniors about eligibility and how to apply.
- **Strategy 4:** Help the aging network rebuild post-pandemic and strengthen its ability to provide a range of nutrition services using innovative strategies and diverse funding sources.
- **Strategy 5:** Create new Senior Nutrition Program training opportunities for AAAs based on needs and/or challenges identified by AAAs.
- **Strategy 6:** Grow the reach of the Senior Farmers' Market Nutrition Program by increasing the number of eligible older adults participating, the number of farmers' markets and farmers accepting coupons, and the coupon redemption rate.
- **Strategy 7:** Support the Governor's Advisory Council on Aging (GAC) in convening a NC Senior Hunger Summit to help identify and evaluate the efficiency and effectiveness of the current nutrition services landscape for North Carolina's older adults.

OBJECTIVE 2.2: Continue to improve transportation for older adults by supporting a more responsive, coordinated, diverse, and inclusive transportation system.

- **Strategy 1:** Seek opportunities to collaborate with NCCARE360 and NC211 to increase referrals by the aging network to transportation resources.
- **Strategy 2:** In partnership with the Older Driver Safety Workgroup of the NC Governor's Highway Safety Program, continue expanding public awareness of driver safety resources and promote safe driving among older adults.
- **Strategy 3:** Provide education about general and medical transportation options to older adults and people with disabilities through community services and supports.
- **Strategy 4:** In partnership with DSDHH, ensure all aspects of communicating transportation information and the transportation system is accessible for people with hearing loss.

OBJECTIVE 2.3: Older adults will have access to evidence-based health promotion, wellness, and disease prevention programs.

- **Strategy 1:** In collaboration with Healthy Aging NC (HANC), research best practices for educating communities about evidence-based health promotion and disease prevention (EBHP/DP) programs.
- **Strategy 2:** Continue working with the AAAs and senior centers in expanding, offering, and promoting EBHP/DP programs.
- **Strategy 3:** Review the monitoring tool for evidence-based programs to ensure that programs are delivered in accordance with federal requirements.
- **Strategy 4:** Partner with HANC to provide technical assistance to the AAAs in the development of a sustainability plan for EBHP/DP programs, including opportunities for contracting with healthcare payers.
- **Strategy 5:** Train the AAAs, and reinforce through monitoring, expectations regarding evidence-based program data reporting.
- **Strategy 6:** Measure effectiveness of the NC Senior Games (NCSG) as a year-round physical and mental health promotion program.

OBJECTIVE 2.4: Maintain a statewide structure to coordinate falls reduction efforts.

- **Strategy 1:** Continue implementation of the current 2021-2025 Falls Prevention Action Plan and participate in the development of the 2026-2030 plan.
- **Strategy 2:** Collaborate with the NC Falls Prevention Coalition to support annual summits to promote evidence-based and evidence-informed strategies for falls prevention.
- **Strategy 3:** Advance clinical-community integration through the NCFPC's referrals pathways workgroup and explore ways to integrate falls prevention referrals into electronic health records (EHR).
- **Strategy 4:** In partnership with NC research institutions, develop screening for fall-related TBI.
- **Strategy 5:** Explore how DAAS, Division of Public Health (DPH), Division of Mental Health/Developmental Disabilities/ Substance Abuse Services (DMH/DD/SAS), and the Division of Vocational Rehabilitation Services (DVRS) can work with NCFPC to form partnerships with brain injury organizations to educate healthcare providers about screening and referrals for brain injury in older adults.
- **Strategy 6:** Work with the NCFPC and aging and disability service providers to increase access to evidence-based and evidence-informed falls prevention programs and education across all counties.
- **Strategy 7:** Develop and promote falls prevention strategies in the State Health Improvement Plan (SHIP) to address drivers that impact health outcomes.
- **Strategy 8:** Educate older adults, healthcare providers, and long-term care facilities on the importance of annual comprehensive hearing evaluations to promote the detection of hearing loss and its connection to falls, dementia, depression and isolation, diabetes, cardiovascular disease, and kidney disease.

OBJECTIVE 2.5: Expand public awareness regarding the benefits of senior centers and their role in the community.

- **Strategy 1:** Provide education and training to senior centers to support their programming, including multigenerational components and inclusivity for historically marginalized and underserved populations.
- **Strategy 2:** Support the NC Senior Center Alliance in the promotion of senior centers and advocacy efforts.
- **Strategy 3:** Provide training to senior centers on existing outreach materials.
- **Strategy 4:** Collaborate with AAAs and representatives from senior centers to evaluate and strengthen the senior center certification program.

OBJECTIVE 2.6: Increase public awareness of mental health challenges and disorders and strengthen social connection systems to mitigate the effects of social isolation, loneliness, and elevated suicide risk.

- **Strategy 1:** Collaborate with Geriatric Adult Mental Health Specialty Teams (GAST) to provide training in mental health and substance use issues and provide support to people working with older adults living in the community.
- **Strategy 2:** Work with DMH/DD/SAS and OoC to host a series of live aging and mental health talk-ins where older adults and caregivers are invited to share questions, concerns, and needs and learn about resources to improve mental well-being.
- **Strategy 3:** Work with DMH/DD/SAS to promote mental health services and educate older adults with severe mental illnesses/severe persistent mental illnesses (SMI/SPMI) about the Transitions to Community Living (TCL) Initiative.
- **Strategy 4:** Partner with stakeholders in the development of training and informational materials about drug use, abuse, and misuse to older adults, people with disabilities, and their caregivers.
- **Strategy 5:** Explore opportunities to expand B.E. With and ASIST trainings to aging service providers and other NCDHHS partners to address social isolation, loneliness, and elevated suicide risk among older adults.
- **Strategy 6:** Incorporate screening for social isolation and referrals to social engagement programs into the information and referral activities, including NCCARE360.
- **Strategy 7:** Continue to partner with the NCCHW to expand the Social Bridging Project to support social connectedness for older adults in all areas of North Carolina.
- **Strategy 8:** Provide training to senior center staff and aging and disability services providers on identifying and addressing social isolation among those identified as being at risk.
- **Strategy 9:** Partner with DSDHH to ensure older adults with hearing loss have access to assistive technology and address the correlation between hearing loss and social isolation.

Housing and Homelessness:

GOAL 3: Adopt an equity-centered housing lens approach[6] to enable older adults to age in their place of choice with the appropriate services, supports, and housing opportunities.

DAAS is working proactively to implement solutions to increase access to long-term services and supports and community-based housing opportunities, increase opportunities for inclusive community living, address gaps in services, and increase the availability of affordable, safe, and accessible housing.

NCDHHS developed the 2023-2028 strategic housing plan to ensure that North Carolinians with disabilities have opportunities for integration and inclusion in their communities. The plan will address the housing needs of individuals with disabilities, currently receiving or eligible for NCDHHS-funded services at the state and local levels, who are either homeless, currently residing in congregate settings or at-risk of entry into these settings. The plan will also provide a strategic guide to focus policy efforts and resource decision making in creating and maximizing community-based housing opportunities for identified populations over a five-year horizon. Additionally, the plan will build on existing Olmstead efforts within the NCDHHS (i.e., Transitions to Community Living [TCLI] and Money Follows the Person [MFP]). The Housing and Homelessness goal of the State Aging Plan will align with the five goals of the Strategic Housing Plan – to Improve and Expand: Housing Development, Non-development Activities that Increase Affordable Housing Access, Housing Support Services, Coordination Among State Agencies Administering Housing Funding and Programs, and Partnerships Across the State that will Increase Affordable Housing.

The Housing Unit, operating in DAAS, is responsible for providing leadership to, and coordination of, activities connected to decent, safe and affordable community housing with access to appropriate and effective supportive services for NCDHHS constituents. These activities are integral to implementation of the State's Olmstead Plan, the 2012 Department of Justice (DOJ) Settlement Agreement with NCDHHS, local 10-Year Plans to End Homelessness, the NCDHHS Strategic Housing Plan, and the Department's mission to support people with disabilities, the elderly and low-income families to achieve maximum independence and self-sufficiency. The Housing Unit works in collaboration with Local Management Entities and Managed Care Organizations (LME-MCO) to help individuals identified in the Transitions to Community Living (TCL) locate and secure affordable, appropriate housing and works with other Authorized Referral Agencies (ARA) to locate and secure affordable, appropriate housing for other people with disabilities, the elderly, low-income and homeless individuals and families. The Housing Unit also oversees implementation of the Key Rental Assistance Program, a state funded rental assistance program that is administered in partnership with the N.C. Housing Finance Agency's Targeted Units. Over the next four years, DAAS will work to secure adequate funding and staffing to support the goals of the NCDHHS Strategic Housing Plan. Currently, plans include expanding the program to a broader range of populations and increasing utilization of Targeted units across the state. One particular effort will be to leverage available Federal voucher programs; the ability to expand the Key Subsidy program will depend on a significant increase in State funding to support increased utilization and the staff necessary to administer the programs.

[6] According to HUD, "rather than adopt an approach centered on health care, in which [older adults] are either healthy or in need of care, the housing lens approach puts a person's dwelling at the heart of their well-being. Moving beyond medicine, the housing lens examines neighborhood safety, the adaptability of the home to aging bodies, the social vibrancy of the community, and the reliability of public transit, among other factors."

Additionally, the North Carolina Emergency Solutions Grant (NC ESG) Office administers the NC ESG program which provides emergency shelter, street outreach, rapid rehousing, and homelessness prevention for the state of North Carolina. The overall goal of the program is to make homelessness rare, brief, and non-recurring. HUD recognizes that the number of older adults experiencing homelessness is growing at a rapid rate. As such, HUD has identified this population as an area of focus for ending and preventing homelessness. All NC ESG service providers who serve this population are putting special emphasis on ensuring that this population is served and that their special needs are met.

The number of older adults experiencing homelessness is increasing, and a recent study conducted by the Alliance's Homelessness Research Institute explores how factors such as shelter status, age, gender, race, and ethnicity can affect their transition from homelessness to secure housing. Some key findings were that older adults tend to seek permanent housing solutions outside of homelessness systems, which can create obstacles for them in obtaining the necessary assistance; additionally, despite their increased needs, older adults are more likely to be connected to Rapid Rehousing instead of more intensive permanent supportive housing solutions.

HOMELESS DATA BY AGE

From 2017-2021 the number of people 62 and older who were homeless increased by 149%

Report: Persons Homeless by Age, NC Balance of State Continuum of Care | Projects Included: Coordinated Entry, Street Outreach, Emergency Shelter, Transitional Housing, Rapid Re-Housing, Permanent Supportive Housing, Homelessness Prevention | Dates/Years: January 1, 2017 - December 31, 2021 | Known data not included: agencies not participating in HMIS including but not limited to victim service providers.

OBJECTIVE 3.1: Promote expansion of home and community-based services to support older adults aging in the least restrictive setting and provide aging-in-place housing improvements.

- **Strategy 1:** Utilize HCCBG and Rapid Rehousing funds to fund home modifications and repair (HMR) for older adults.
- **Strategy 2:** In partnership with the Independent Living Rehabilitation Program, address the barriers to home modification access and service delivery by increasing the availability and awareness of home modification at the state and local levels.
- **Strategy 3:** Increase awareness of housing and home improvement services and promote mobility and accessibility services as a means of keeping people safe in their home.
- **Strategy 4**: Work with the AAAs to encourage Housing and Home Improvement (HHI) providers to use a Prioritization tool as best practice in the management of HHI waitlist.
- **Strategy 5**: Support adults of all ages to transition from facilities to home and community settings through the Money Follows the Person (MFP) Demonstration Grant.

OBJECTIVE 3.2: Increase affordable housing opportunities, provide permanent supportive housing (PSH), and support a coordinated, comprehensive system of services to address, prevent, reduce, and end chronic homelessness among older adults.

- **Strategy 1:** Utilize Rapid Rehousing funds to help support eviction prevention to include emergency rent assistance, tenancy supports, and flexible use of funds to support tenants in their housing.
- **Strategy 2:** In collaboration with NCDHHS and its housing and service stakeholders, support implementation of the goals, objectives, and strategies of the NCDHHS Strategic Housing Plan to eliminate barriers to housing and create quality affordable, accessible, and inclusive housing that supports the whole individual by improving services, funding, communication, and statewide coordination for the population we serve.
- **Strategy 3:** Provide training and technical assistance on homelessness to service providers at the state and community levels to establish an infrastructure that supports homeless service activities across systems of care.
- **Strategy 4:** Encourage participation in the targeting housing program among older adults and people with disabilities through partnerships with funded providers and local DSS offices to promote aging populations successfully moving into affordable housing.
- **Strategy 5:** Identify existing opportunities and other potential mechanisms to support learning for older adult community services providers about best practices, possible uses for HCCBG funding, and other considerations to help ensure safe and affordable housing for older adults.
- **Strategy 6**: Identify what types of data are needed to measure progress in addressing homelessness, as well as methods by which to obtain this data.
    - **Sub-strategy 6:** Collect, analyze, and report high-quality, timely data on homelessness to address inequities.

Caregiving and Workforce Development:

GOAL 4: Advance equity, accessibility, and inclusion through informal and formal caregiving support.

As the aging population continues to grow, the need for caregivers significantly increases and puts caregivers at risk of increased, stress, depression, and poor health outcomes. Additionally, the health risk and burden of caregiving can hinder a person's ability to provide care, lead to higher health care costs, and affect quality of life for both the caregivers and care recipients. From the National Core Indicators Aging and Disability (NCI-AD) Survey, the desire for caregiver support services and the service used by people with dementia has increased significantly among all races/ethnicities from 2016-2019 to 2021-2022. These numbers showcase the growing public health crisis and the importance of adopting a public health approach to lessen the burden, and subsequently enhance the quality of life. Furthermore, including a module consisting of questions about caregiver in the Behavioral Risk Factor Surveillance System Survey (BRFSS) of the NC State Center for Health Statistics has enabled us to track the prevalence and impact of family caregiving. In the 2021 Behavioral Risk Factor Surveillance System (BRFSS), 17% of NC caregivers reported giving regular care or assistance to a friend or family member with a health problem or disability. Of these caregivers, the main health problem of the person receiving care was reported to be a hypertension, diabetes, and organ failure/disease (31%), disability (28%), and dementia and other cognitive impairment (16%). Nearly 48% of these caregivers reported providing care weekly for up to 8 hours and 30% for 40+ hours; 38% of caregivers reported caregiving for more than five years. This same survey showed that 48% of NC's caregivers managed care recipient's personal care and 75% managed personal tasks. Seventy-nine percent of caregivers are caring for a person aged 65 and older. According to the ACL 2022 National Strategy to Support Family Caregivers, regardless of the age of the care recipient, when family caregivers no longer can provide support, their loved ones often are left with no choice except moving to an institutional or long-term care setting. Strengthening caregiver's ability to provide quality care in the home through training, support, and opportunities for rest and self-care and equipping family caregiver supports and services is key to sustaining our nation's long-term care system.

In 2020, there were an estimated 300,000 North Carolinians living with Alzheimer's Disease or a related dementia and an additional 356,000 caregivers were also affected by it. From 1999 to 2019, the number of Alzheimer's deaths in the state increased 145% while deaths from heart disease increased only 5% during that same period. The number of people in NC living with dementia is expected to increase to 400,000 by 2025 and there will likely be a shortage of available health care

workers to care for them. The number of doctors specializing in the care of older adults will need to increase 239% by 2050 in order to meet the anticipated demand. In September 2020, the North Carolina Division of Aging and Adult Services was awarded $960,000 (over three years) from the BOLD Infrastructure for Alzheimer's Act. Having already completed an update to its dementia strategic plan, North Carolina is now poised to begin implementation of the recommendations in the plan in order to build public health infrastructure statewide and focus on risk reduction through the measures listed above, increasing early detection and diagnosis, prevention of avoidable hospitalizations, and supporting dementia caregiving.

In 2021-2022, as part of the BOLD NC initiative, the North Carolina Institute of Medicine, in partnership with NCDHHS, undertook a stakeholder engagement process to align the overall visions of both BOLD NC and Dementia-Capable North Carolina. The process was designed to add to the Dementia-Capable NC Strategic Plan with a focus on overall brain health and public health engagement with brain health promotion over the course of the lifespan. Through a series of four meetings facilitated by NCIOM staff in 2021-2022, participants reviewed a subset of the 2016 recommendations identified by the steering committee and discussed specific and actionable revisions to the recommendations that would incorporate four actions from the CDC's Healthy Brain Initiative *State and Local Public Health Partnerships to Address Dementia: The 2018-2023 Road Map*.

Although providing care to a family member can be a positive and rewarding experience, family care can be stressful. Some caregivers live with their relative while others are long-distance caregivers and must travel or coordinate care over the phone. Over one-half of all caregivers are employed full-time and many have other family responsibilities. The physical, emotional, and financial demands can be overwhelming. Although studies have shown that the use of formal services may reduce some of the burden associated with care, many caregivers do not use outside or formal service. North Carolina has recognized the importance of family care and has offered services to benefit caregivers for a number of years. The North Carolina Family Caregiver Support Program strives to make information, supports, and services available as needed and desired by caregivers and to help caregivers know that they are not alone. North Carolina administers the Older Americans Act programs through a Home and Community Care Block Grant. The block grant provides in-home and community-based services for older adults and their unpaid caregivers. Block Grant services specifically for caregivers include in-home, group and institutional respite. Project CARE is funded through NC special appropriations and the Lifespan Respite is funded through a federal grant.

	Project CARE (State Appropriation)	Family Caregiver Support Program (OAA-Title IIIE)	Lifespan Respite Vouchers (Time-limited federal grant)
Eligibility	Caring for someone with ADRD and receiving no other care consultation service	• Any age caregiver, caring for person 60+ with Alzheimer's or related brain disorder • Caregiver (not parent), 55+, raising child (≤ 18), or adult with disability • Parent caring for adult with disability	• Caregivers of children with special needs • Caregivers do not apply; local community services agency or human service professionals apply
Services Offered	• Outreach and education • Information and assistance • Care consultation	• Outreach and education • Information and assistance • Supplemental services for frail	Caregivers reimbursed for adult day care, summer camp, overnight respite, etc.
Respite	• Up to three $500 respite/SFY Reimbursement based • Limit $2,500 alone or combined with FCSP	• Type(s) and amount of service vary by county • Recipient must meet OAA frail definition • Limit $2,500 alone or combined with Project CARE	• Up to $500 voucher/year • Prioritize those not receiving respite in last six months • Caregiver reimbursed
Access	Family consultants	Area agency on aging and providers	Applications submitted by staff

OBJECTIVE 4.1: Strengthen, support, expand, and diversify the direct care workforce to meet the growing care needs in NC.

- **Strategy 1:** Explore recruitment of older workers to provide direct care using Title V training funding to pay for Personal Care Aide or Certified Nursing Assistant (CNA) training.
- **Strategy 2:** To enhance best practices, encourage home care agencies and educational institutions to partner with state agencies to support a ready and well-qualified direct care workforce.
- **Strategy 3:** In collaboration with DMH/DD/SAS, provide support to providers on trauma-informed care.
- **Strategy 4:** Expand opportunities for community involvement and volunteerism to increase the availability of services to older adults, people with disabilities, and family caregivers.

OBJECTIVE 4.2: Leverage resources and flexibility to provide Family Caregiver Support Program (FCSP) services across all five service categories – information, access, training/support, respite, and supplemental services – in all 100 counties.

- **Strategy 1:** During the ARPA project period, continue using these funds to offer respite care services and broaden supplemental service offerings.
- **Strategy 2:** DAAS FCSP will engage with the NC Caregiving Collaborative to prioritize the recommendations of the Raise Family Caregiver Report and develop an implementation strategy for advancing policy solutions for caregiving across the life span.
- **Strategy 3:** Help direct caregivers to the most appropriate services through the aging network including supporting older relatives as caregivers.
- **Strategy 4:** In collaboration with the AAAs, conduct program evaluation to identify strengths, challenges, and opportunities for improvement.
- **Strategy 5:** Support the promotion and use of NC Caregiver Portal (Trualta), with an expanded emphasis on social isolation for caregivers.
- **Strategy 6:** In collaboration with DPH, provide an analysis on the health status of NC family caregivers using the Caregiver module included in the BRFSS survey.

OBJECTIVE 4.3: Support the expansion of Project CARE (Caregiver Alternatives to Running Empty) services to unpaid caregivers of people living with Alzheimer's disease or other related dementias and explore additional grant opportunities to continue Lifespan Respite.

- **Strategy 1:** DAAS' NC Lifespan Respite State Advisory Team will apply for ACL grant funds to sustain Lifespan Respite Voucher Program in 2023 to continue dissemination and expansion of respite services across the lifespan.
- **Strategy 2:** Maintain an inventory of publicly funded respite options in NC.
- **Strategy 3:** Evaluate the capacity of individuals to use consumer direction for respite services.
- **Strategy 4:** Seek funding to increase state allocation for Project CARE services to strengthen infrastructure and expand coverage across NC.
- **Strategy 5:** Participate in the NC Caregiver Collaborative to analyze state data, legislative solutions, financing options, and promote best practices and strategies for supporting caregivers in NC.

OBJECTIVE 4.4: Raise awareness of impacts and challenges of Alzheimer's disease and related dementias for North Carolinians.

- **Strategy 1:** DAAS will continue to work on BOLD NC initiatives focusing on risk reduction, advancing early detection, and supporting caregivers.
- **Strategy 2:** Provide leadership to a dementia-friendly communities workgroup for community leaders interested in beginning or growing a dementia-friendly community.
- **Strategy 3:** Train Dementia Friends Champions across the state to adopt appropriate language around dementia.
- **Strategy 4:** In partnership with the NC Dementia-Capable Coalition, work to accomplish recommendations of the NC Dementia Capable State Plan.
- **Strategy 5:** In partnership with the College of Health and Human Services at NC A&T, Center for Integrative Health Disparities and Health Equity, explore the shared risk and protective factors between brain health and other preventable risk factors/health behaviors, such as intellectual or developmental disabilities (IDD).

OBJECTIVE 4.5: Strengthen the "No Wrong Door" (NWD) access to aging and disability services and promote the development of a state system of long-term care that is coordinated.

- **Strategy 1:** Support the NC Center for Health and Wellness (NCCHW) in the creation of a No Wrong System through a 2-year implementation plan and governance structure.
- **Strategy 2:** Support the intersection of the NWD Governance Structure with the Multisector Plan on Aging through support from the Center for Health Care Strategies (CHCS) and ACL.
- **Strategy 3:** Support person-centered planning for older adults and their caregivers across the spectrum of LTSS, including home, community, and institutional settings.
- **Strategy 4:** Increase education and awareness through NC CARE360/NC 211 about how caregivers access long-term services and supports.

OBJECTIVE 4.6: Ensure that people who need additional care can stay in their community and in the living arrangement of their choice.

- **Strategy 1:** Recommend in-home service employers implement a regular program of ongoing training and education for staff providing in-home services of at least 12 hours, with a focus on diversity, equity, and inclusion, disability sensitivity and communication equity.
- **Strategy 2:** In collaboration with the AAAs, DAAS will offer training to promote the expansion of participant directed/person-centered models of providing care.
- **Strategy 3:** Educate local in-home aide service providers about the use of the American Rescue Plan Act of 2021 (ARPA) funding and strategize ways to forecast funding to address waitlists and shortages of staffing.

OBJECTIVE 4.7: Promote social, physical and emotional well-being through Adult Day Services and Program of All-Inclusive Care for the Elderly (PACE) program.

- **Strategy 1:** Support DHB in expanding PACE service areas across the state and increase capacity of existing programs by disseminating informational resources.
- **Strategy 2:** Conduct an evaluation of adult day care and day health programs, funding sources, and accessibility and transportation barriers.
- **Strategy 3:** Support expansion efforts in rural areas and equitable access for lower income populations.

Long-term Preparedness Planning:

GOAL 5: Incorporate innovative practices learned through COVID-19 and create reliable systems and infrastructures that will have the capacity to serve the growing aging population, all while recognizing the need for communication equity to foster involvement from all stakeholders.

The COVID-19 crisis has not only spotlighted the need to incorporate innovative practices, emphasize a coordinated system of response, and expand and improve planning, but has also exposed the existing and long-standing vulnerabilities in service delivery. The lessons learned from the pandemic are guiding DAAS to evaluate current policies and improve existing structures in order to implement system-level changes to better serve the aging and disability population.

To evaluate current policies and improve existing structures, a sustainability plan will be developed that will be based on a program evaluation study that will clearly demonstrate the service/program outcomes and service expansion of the ARPA funded services and reflect the benefits to older adults and their families. DAAS and the AAAs will collaborate to develop and implement this program evaluation. Important metrics that will be included that pertain to service expansion are:

- documenting the increase in the number of people served.
- documenting additional service provision to current service recipients (i.e. identifying additional service units such as more hours of IHA provided per week).
- identifying new and different services provided with ARPA funds.
- documenting the number of new service providers that will enable the program to reach more people.
- strengthening the provider infrastructure that enhance the capacity of providers to provide additional services, and policy changes that will enhance service flexibilities with existing service standards, which could result in changes to traditional HCCBG services to open up further service provision.

Additionally, across the country, states are recognizing the need to conduct high-level, cross-sector planning to prepare for the aging population and ensure that the needs of older adults, people with disabilities, and family caregivers are met over the coming decade. A Multisector Plan for Aging (MPA) establishes a 10-year blueprint that guides the restructuring of state and local policy and programs while connecting the public, private, and independent sectors in modernizing and creating systems-based solutions that touch all major areas of the aging life experience. By May 2024, NCDHHS, in collaboration with the MPA Stakeholder Advisory Committee (SAC) and subcommittee members, hope to produce a two-year blueprint of the 10-year plan.

CROSS-SECTOR → **STATE-LED** → **STRATEGIC PLANNING RESOURCE**

OBJECTIVE 5.1: Evaluate current systems and infrastructures in response to the evolving needs, services, and communication access for our aging population's well-being.

- **Strategy 1:** In partnership with the AAAs, local service providers, advocates, and other key stakeholders, develop ARPA Sustainability plan through in-depth ARPA program evaluation and advocacy efforts.
  - **Sub-strategy 1:** Conduct fiscal and programmatic monitoring to ensure that all COVID-19 related funds are expended as stipulated by ACL through in-depth ARPA services program evaluation to identify strengths, challenges, and opportunities for improvement.
  - **Sub-strategy 2:** Examine initiatives undertaken with ARPA funds to determine innovations that should be continued with necessary state support.
- **Strategy 2:** Promote the expansion of home and community-based services to support older adults aging in the least-restrictive setting through increasing services.
- **Strategy 3:** Support the business capacity and acumen of the AAAs through various methods, such as supporting the development of a Community Care Hub.
- **Strategy 4:** In collaboration with the AAAs, implement local pilots to allow for innovation, creativity, and flexibility which recognizes, values, and incorporates into planning the regional and community diversity.

OBJECTIVE 5.2: Implement operational improvements and managerial efficiencies for critical services and supports.

- **Strategy 1:** Educate other divisions regarding programs available through DAAS and how the division may assist through partnering.
- **Strategy 2:** Improve performance-based outcomes for services by adopting an active contracts management framework to educate vendors and providers.
- **Strategy 3:** Expand and improve performance measures for DAAS programs and services in N.C. NCDHHS Open Window (DHHS Open Window captures information on services, programs, contracts, key planning and performance information).
- **Strategy 4:** Update DAAS policies, procedures, and manuals, setting measurable goals in services and contracts to assure best practice standards in compliance with the 2020 OAA Reauthorization.
- **Strategy 5:** Convene a workgroup of AAAs, providers, and DAAS staff to effectively monitor a waiting list policy for services provided by the Home and Community Care Block Grant.
- **Strategy 6:** Implement NCDHHS DAAS Modernization Roadmap Plan that integrates DAAS data, processes, and applications in phases.
- **Strategy 7:** Support data modernization efforts by using asset framing approaches and ensuring that data collection, analysis, interpretation, and dissemination are equity centered.
- **Strategy 8:** Make infrastructure improvements by evaluating and modifying the internal structure of DAAS to ensure effective and efficient management and delivery of services.
- **Strategy 9:** Revise or replace the DAAS 101 Client Registration to ascertain client needs more effectively.

OBJECTIVE 5.3: Expand efforts to assist older adults, people with disabilities, and their caregivers with emergency management and disaster preparedness planning, response, and recovery with communication equity.

- **Strategy 1:** Promote effective collaboration and coordination with North Carolina Emergency Management (NCEM) and leverage their successful partnership in the work of the State Emergency Response Team (SERT).
- **Strategy 2:** Collaborate with the AAAs and local emergency response agencies to provide additional support and encourage the expansion of the "call-down" logs systems and other appropriate communication processes to contact those with the highest social and economic needs prior to and following a hurricane and other natural events.
- **Strategy 3:** Strengthen emergency preparedness and response for older adults and people with disabilities to improve responsiveness through collaboration with the Emergency Operations Center (EOC) CMIST Advisory Committee.
- **Strategy 4:** DAAS will serve on the NC Emergency Management Registry Workgroup to explore and/or develop tools, processes, best practices, trainings, and toolkits for county and municipalities desiring to assist their residents with access and functional needs during a disaster.
- **Strategy 5:** Assess lessons learned from the COVID-19 pandemic to strategize, develop, and update communication plans, policies, and procedures and continue supporting ongoing COVID-19 response and recovery needs, such as vaccine information and assistance.

- **Strategy 6:** DAAS will support recovery efforts by coordinating with the disaster team and key players to provide annual trainings and assigning and deploying appropriate personnel to assist county departments of social services, area agencies on aging and other local entities as requested.
- **Strategy 7:** DAAS will encourage local providers and the AAAs to embed DEI trainings into emergency planning.
- **Strategy 8:** Collaborate and consult with the DSDHH regional staff to ensure that communication access is provided before, during, and after events.

OBJECTIVE 5.4: Develop a cross-sector, state-led multi-sector plan to transform the infrastructure and coordination of services for our rapidly aging population.

- **Strategy 1:** In partnership with DHB, mine data across departments and examine existing research to identify current and future trends in the aging and disability population.
- **Strategy 2:** Map past and current initiatives in NC including state, regional, and local efforts to create a tapestry and coordinated infrastructure around all various aging initiatives occurring in North Carolina.
- **Strategy 3:** Form governance structure for MPA Stakeholder Advisory Committee to drive the collaborative effort to develop the 10-year plan.
- **Strategy 4:** Age my Way NC partners will study ways to promote age-friendly efforts and evaluate the need for new state programs to address challenges.

OBJECTIVE 5.5: Support the implementation of the Medicare-Medicaid integration strategy to better meet the diverse needs of the aging population.

- **Strategy 1:** Older adults and the community aging and disability providers who serve them will be educated on the availability of services that foster independence, self-sufficiency, enhance planning, and communication access.
- **Strategy 2:** Educate older adults about the Medicare-Medicaid dual-eligibility, structure, and phase in of populations and services.
- **Strategy 3:** Collaborate with other NCDHHS divisions to increase Medicaid administrative claiming and provide eligible individuals access to Medicaid treatment.
- **Strategy 4:** Develop workflows to ensure continuity of care and seamless experiences for individuals as they transition to MLTSS program.

Advancing Equity:

GOAL 6: Advance equity by supporting and encouraging older adults of all backgrounds and their support systems to access information that helps them make informed choices about support services at home or in the community.

DAAS is committed to strengthening support for an increasingly diverse aging population and recognizes that each community is unique. DAAS is also committed to helping all older adults age well by targeting people in the greatest social and economic need and by bringing a diversity, equity, and inclusion (DEI) lens to all of our communication, products, and services.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP):

The Senior Community Service Employment Program (SCSEP) is the only federally funded work-based job training program for adults 55+. The program was created by the Older Americans Act of 1965 and is administered by the Department of Labor. The State of North Carolina SCSEP Program administers the SCSEP Program in 24 counties under two sub-grantee partners: AARP Foundation and Iredell Council on Aging. Other national providers in the State of North Carolina are: National Caucus and Center on Black Aging (NCBA), National Council of Aging (NCOA), and the Center for Workforce Inclusion (CWI). The SCSEP Program is administered and covers 99 counties in NC. The SCSEP Program promotes healthy aging by offering employment opportunities for low-income older NC residents and by providing a labor force to programs and agencies that help serve more people and provide good community service. A majority of the SCSEP participants are ethnic minorities which include Black, Asian, Hispanic and Pacific Islander.

DAAS DEI COUNCIL:

Additionally, within the division, DAAS is working towards creating a more equitable and inclusive workforce and has established a DAAS DEI Council. To achieve this, the organization has taken several steps, including conducting an Awareness Survey with over 65% participation rate. A Fireside Chat with Assistant Secretary Angela Bryant was held to discuss DEI and how the Office of Equity can play a role in providing leadership and guidance to the Department. To recognize the celebratory months of major ethnic groups, DAAS has provided staff with virtual guided tours of topics of interest, lunch and learns, interactive forums, and links to agencies and organizations that foster greater understanding of the principles fundamental to DEI. Moving forward, each section of DAAS will take a deeper look into their service provision to best determine how DEI can be integrated into division efforts.

In the next four years, DAAS will continue its efforts to enhance and modernize services and program delivery systems for older adults, adults with disabilities, and their families and caregivers. By working with partners and stakeholders, DAAS will achieve the goals and objectives of this State Plan.

DIGITAL EQUITY:

Moreover, DAAS plans to address the digital equity needs of older adults; digital equity is necessary for civic and cultural participation, employment, life-long learning, and access to essential services. All individuals and communities have the information technology capacity needed for full participation in our society, democracy, and economy. One of the greatest challenges impacting older adults is the lack of experience and skills using technology. A second challenge is lack of access to broadband and devices, particularly in rural communities. While there are programs and resources to address digital equity, they are not geared toward the unique needs of older adults.

Over the next few years, DAAS hopes to create a scalable, master digital health navigator trainer program responsible for supporting digital navigator services and community-based partners across the state that also will enhance the ability to deliver and sustain equitable, useable, and community-centered digital equity training for and with older North Carolinians. This program seeks to address multiple and overlapping "domains of livability" (AARP) for aging adults, including social participation, work and civic engagement, communication and information, access to state and local information about transportation options, and community health services.

OBJECTIVE 6.1: Continue to expand equity-centered communications to older adults, people with disabilities, and families of all backgrounds.

- **Strategy 1:** Partner with the AAAs and other community organizations to design and implement outreach and training plan with communication access to support OAA funded programs throughout NC.
- **Strategy 2:** In coordination with the AAAs, review, evaluate, and revise all internal policies, procedures, and outreach materials to focus on using person-centered language and promote equity and inclusion.
- **Strategy 3:** Research marketing and outreach programs, as well as best practices, to increase participant diversity in evidence-based health promotion and disease prevention programs.
- **Strategy 4:** In collaboration with the Office of Diversity, Equity, and Inclusion, strategize ways to incorporate inclusivity in our programs and events, through racial diversity in marketing materials, ability/disability, diversity in sexual orientations, diversity in gender identities, veteran engagement, and increased communication access and language resources.
- **Strategy 5:** Work with the DSDHH, Division of Services for the Blind (DSB), the NC Department of Military and Veteran Affairs (DMVA), and the DVRS to devise a plan to allow access to provide regular training to aging service providers.
- **Strategy 6:** Through partnerships with universities and organizations, explore ways to collect inclusive data about sexual orientation and gender identity in program evaluations.
- **Strategy 7:** Address stigma attached to aging and needing services by using a Personal Determinants of Health (PDOH[7]) approach and increasing opportunities for multigenerational community activities and partnerships with local organizations, such as school systems.

[7] This framework can act as a complement to Social Determinants of Health (SDOH) with the intention of creating a holistic picture of one's health. Researchers with UnitedHealthcare and AARP Services, Inc. (ASI) developed a framework called Personal Determinants of Health (PDOH) for understanding the factors that help us cope with adversity and thrive through aging. These characteristics also tend to help people get the most out of their health care experiences, provider interactions and community resources. This framework can act as a complement to SDOH with the intention of creating a holistic picture of one's health. The idea of PDOH depends upon on strong resilience — the ability to bounce back from life's challenges and cope with difficult experiences — which individuals may build and improve upon as they age. https://newsroom.uhc.com/experience/personal-determinants-of-health.html

- **Strategy 8:** Educate aging network to begin by using inclusive terms, phrases, and language that do not presume a sexual orientation, gender identity, or relationship status and also explore LGBTQ-specific programming to create a welcoming and inclusive environment for all older adults.
- **Strategy 9:** In partnership with the Office of the Governor, the NC Coalition on Aging (NCCOA), and advocacy organizations, such as AARP NC and SAGE USA, work to educate policymakers and promote an "Aging in All Policies."
- **Strategy 10:** In Collaboration with the Office of Diversity, Equity, and Inclusion, increase the knowledge and skills of staff about diversity, equity, and inclusion through DAAS DEI council and Department DEI council work.

OBJECTIVE 6.2: Foster equity and inclusion across multiple structurally excluded and inadequately represented populations of greatest social and economic need and their community networks.

- **Strategy 1:** Implement local and national best practice initiatives and equitable communication in all aspects of daily living to empower residents to exercise autonomy over their lives in long-term care settings.
- **Strategy 2:** In collaboration with the AAAs, make long-term investments in native community-based infrastructure with grants, contract services, technical assistance, and other targeted resources to support the social and healthcare needs of older adults and their family caregivers.
- **Strategy 3:** Collaborate and provide technical assistance to Native Americans and advocates in their communities to promote access to available services.
- **Strategy 4:** Encourage the aging network to engage in outreach and co-host programming with local LGBTQ+ organizations and HIV providers.
- **Strategy 5:** In partnership with SAGE USA and local partners, prepare, publish and disseminate educational resources about available services and resources for people living with HIV through partnerships with HIV service providers and for LGBTQ+ older adults with LGBTQ+ organizations.
- **Strategy 6:** Implement culturally appropriate educational and coaching strategies to help historically marginalized family caregivers safely, competently, and confidently navigate the state's social services and healthcare systems.
- **Strategy 7:** Collaborate with El Centro's Department of Civic and Community Participation to implement culturally appropriate educational training and resources and host events in collaboration with local senior centers.
- **Strategy 8:** Identify organizations that have dedicated holocaust survivor programs and disseminate information to the aging network.
- **Strategy 9:** Increase outreach through the AAA area plans to consumers with limited English proficiency.
- **Strategy 10:** Through community inclusion and strengthened collaboration with public-private partnerships, such as businesses, training institutions, and the AAAs, increase awareness of and participation in the Senior Community Service Employment Program (SCSEP) to reach the capacity of the program.
- **Strategy 11:** In collaboration with the AAAs, ensure that professionals in rural areas have access to training and technical support.
- **Strategy 12:** Collaborate with DSDHH to identify ways to increase involvement of the Deaf, Hard of Hearing, and DeafBlind community in DAAS initiatives and programs.

OBJECTIVE 6.3: Advance digital equity and connectivity literacy by supporting a comprehensive person-centered, community-involved approach.

- **Strategy 1:** Work with North Carolina Department of Information Technology's (DIT) Office of Digital Equity and Literacy to ensure that collaborative digital equity projects are inclusive of older adults and all promotional materials are provided with communication access.
- **Strategy 2:** Contract with the Center for Digital Equity to develop a unified systematic approach to address the needs for digital inclusion and literacy of older adults by creating a project toolkit, curriculum, and train-the-trainer materials across the state.
- **Strategy 3:** Explore opportunities for expanding partnerships with the North Carolina Assistive Technology Program and The Division of Services for the Deaf and Hard of Hearing to ensure older adults have safe and reliable support agencies that can consult with consumers, professionals and others to build their capacity to use or provide digital equity and connectivity that is physically and communication accessible.
- **Strategy 4:** Align work with NCCHW's Social Bridging Project to ensure digital equity needs are addressed.

CONCLUSION

DAAS is committed to addressing the diverse needs of North Carolina's rapidly growing older adult population, and we look forward to collaborating with the various stakeholders, including state government representatives, local partners, and private organizations. The plan's six goals establish a framework and vision for advancing North Carolina. Using baseline data, progress will be measured and annual updates on growth, challenges, and areas for opportunity will be provided. To achieve the goals defined in this plan, actions are required by state, regional, and local agencies, and interests. In moving forward, DAAS is aware of the needs of our state and it's people, but also recognize the importance of collaboration, efficient service administration, targeted resource allocation, and accountability for improved outcomes. We are confident in our understanding of the state's needs and our capacity to address them through collective effort. It is only with the support and strength of the many varied stakeholders that we can hope to achieve the Plan's goals.

ACKNOWLEDGMENTS

DAAS appreciates the individuals who contributed ideas and information during the development of the 2023-2027 State Aging Services Plan and would like to extend a thank you to the following organizations involved in the State Aging Plan Committees: Area Agencies on Aging, Governor's Advisory Council on Aging, Senior Tar Heel Legislature, NC Coalition on Aging, Division of Health Benefits, Division of Mental Health/Developmental Disabilities/ Substance Abuse Services, Division of Services for the Blind, Division of Services for the Deaf and Hard of Hearing, NCDHHS Office of Diversity Equity, and Inclusion, Foundation for Health Leadership & Innovation, El Centro, SAGE USA, Carolina Aging Alliance, Orange County Department on Aging, NC Center for Health and Wellness, Resources for Seniors, West Marion Community Forum, and WNC Bridge Foundation. The State Plan on Aging also benefited from the invaluable assistance of the DAAS Service Operations section, Elder Rights and Special Initiatives section, Adult Services section, Housing section, and Budget section. We would also like to thank the DAAS Planning section and leadership team, who were responsible for the overall development of the plan.

Dedicated to the memory of Joseph Breen

JUNE 2, 1953 – OCTOBER 2, 2022

NC Division of Aging and Adult Services
Section Chief of Planning, ESG and Service Support Section

"Never, ever be afraid to make some noise and get in good trouble, necessary trouble" - John Lewis

ATTACHMENTS

II. ATTACHMENTS

A. STATE PLAN ASSURANCES

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2020.

Sec. 305, ORGANIZATION

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

(2) The State agency shall—

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

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

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

(F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and

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

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

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

(c) An area agency on aging designated under subsection (a) shall be—...

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

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

Note: States must ensure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306, AREA PLANS

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low- income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

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

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

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

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

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4) (A)

(i)

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

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

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

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

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

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

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

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

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older individuals in the planning and service area;

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

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

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

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

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

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

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

(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

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

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

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C) (i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

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

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

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

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and (C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) (A) provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including—

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

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

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

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

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

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

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

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

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

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

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

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

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

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

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

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

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

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

(18) provide assurances that the area agency on aging will collect data to determine—

(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and

(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019.

(b) (1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

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

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness;

(K) protection from elder abuse, neglect, and exploitation; (L) assistive technology devices and services; and

(M) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d) (1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f) (1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2) (A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

(i) providing notice of an action to withhold funds;

(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3) (A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—

(1) contracts with health care payers;

(2) consumer private pay programs; or

(3) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

Sec. 307, STATE PLANS

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two, three, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

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

(B) be based on such area plans.

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

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

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

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).

3. (3) The plan shall—

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

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

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

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

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

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

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

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

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

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

(7) (A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

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

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

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

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

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

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

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

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that—

(A) the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2019, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2019; and

(B) funds made available to the State agency pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712.

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

(11) The plan shall provide that with respect to legal assistance —

(A) the plan contains assurances that area agencies on aging will (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

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

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

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

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

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

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

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

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

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

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

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

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

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

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

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

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

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

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

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

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

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

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

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

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

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

(iv) older individuals with severe disabilities;

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

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

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

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

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

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

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

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

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

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

(21) The plan shall—

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

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

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

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

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

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

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

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

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

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

(B) Such assessment may include—

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

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

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

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

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

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

(30) The plan shall contain an assurance that the State shall prepare and submit to the Assistant Secretary annual reports that describe—

(A) data collected to determine the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019;

(B) data collected to determine the effectiveness of the programs, policies, and services provided by area agencies on aging in assisting such individuals; and

(C) outreach efforts and other activities carried out to satisfy the assurances described in paragraphs (18) and (19) of section 306(a).

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

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

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS

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

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

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

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

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

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

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

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

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

(ii) receipt of reports of elder abuse;

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

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

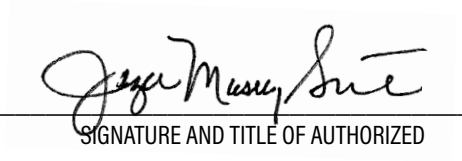
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

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

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

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

(iii) upon court order...



SIGNATURE AND TITLE OF AUTHORIZED

6/2/23

OFFICIAL DATE

B. INFORMATION REQUIREMENTS

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

Section 305(a)(2)(E)

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

RESPONSE:

- The division will continue to emphasize service provision to older adults with the greatest economic and/or social needs, with attention paid to low-income minority older adults and older adults residing in rural areas.
  - In the development of the 2023-2027 State Aging Services Plan, input was solicited from a variety of advocacy groups representing the interests of low-income older adults, low-income minority older adults, and older adults residing in rural areas through regional listening sessions and surveys. Selection of listening sessions were also determined based on demographical data and service waitlists.
  - The division plans to undertake efforts to include individuals isolated due to sexual orientation or gender identity in the definition of greatest social need by added strategies highlighting ways we will conduct outreach to LGBTQ+ older people who need services in their communities.
- The division has targeted resources to the populations with special needs by using an approved intrastate funding formula based on these factors: general population aged 60 and older (50 percent); low-income population aged 60 and older (30 percent); minority population aged 60 and older (10 percent); and rural population aged 60 and older (10 percent).
- The division requires each Area Agency on Aging to develop specific service objectives associated with low-income and low-income minority older adults, older adults residing in rural areas, and other populations at risk and with special needs.
- The division also maintains the Aging and Resource Management System (ARMS) database of clients served, which further analyzes the outreach to clients who are socially and economically needy, living in rural areas, or minorities.
- The division also maintains a website which includes state and county demographic profiles, including economic and social indicators and other special reports (www.ncdhhs.gov/divisions/daas/datareport).
- All goals of the 2023-2027 State Aging Services Plan prioritize taking an equity lens, with the equity goal in specific focusing on advancing equity across multiple underserved populations of greatest social need, expanding equity-centered communications to older adults, people with disabilities, and families, and developing an equitable, person-centered, community-involved approach to addressing social isolation and loneliness

Section 306(a)(6)(I)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will, to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

RESPONSE:

- Under the Equity goal's objective on digital equity, the Division of Aging and Adult Services will explore opportunities for expanding partnerships with the NC Assistive Technology Program to promote independence for people with disabilities through access to technology.
- The division will also work with each of our Area Agencies on Aging to provide guidance regarding the state assistive technology entity and provide education/training regarding assistive technology options for our older adult population.
- Upon providing guidance and training to our AAAs, the division will verify that assistive technology information is addressed in the Area Plans.

Section 306(a)(17)

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

RESPONSE:

- The division works closely with North Carolina Emergency Management (NCEM) and leverage their successful partnership in the work of the State Emergency Response Team (SERT) and the Emergency Operations Center (EOC)
- The Long-term Preparedness Planning goal of the 2023-2027 State Aging Plan emphasizes efforts to assist older adults, people with disabilities, and their caregivers with emergency management and disaster preparedness planning, response, and recovery with communication equity:
  - One such way coordination will occur is through collaboration with the AAA's and local emergency response agencies to provide additional support and encourage the expansion of the "call-down" logs systems and other appropriate communication processes to contact those with the highest social and economic needs prior to and following a hurricane and other natural events
  - We also plan to encourage our AAAs to embed DEI training into their emergency planning work
- The division plans to assess lessons learned from the COVID-19 pandemic to strategize, develop, and update communication plans, policies, and procedures and continue supporting ongoing COVID-19 response and recovery needs, such as vaccine information and assistance.
- The division requires that the AAAs include comprehensive emergency preparedness and disaster response plans to identify and respond to the needs of older adults in their region that is up-to-date.
- Each AAA has working relationships with local emergency response agencies, relief organizations, local governments, and/or other institutions responsible for disaster relief service delivery to respond to hurricanes, floods, tornados, and other storms and pandemics professionally and promptly.

Section 307(a)(2)

The plan shall provide that the State agency will —...

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

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

RESPONSE:

- The division has established the following minimum proportion of the funds received by each area agency on aging to provide part B services listed below:
  - Thirty percent for services associated with access;
  - twenty-five percent for in-home services; and
  - two percent for legal assistance.

This requirement is included in the area plan.

Section 307(a)(3)

The plan shall—

...

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

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

(ii) *identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and*

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

RESPONSE:

- The division requires each service provider to submit annually a completed DOA-733 form, titled "Methodology to Address Service Needs of Low-Income Minority Elderly and Rural Elderly."
- The division uses an approved Intrastate Funding Formula that includes a rural factor, to ensure that aging services funding flows to rural areas.
  - The division has targeted resources to the populations with special needs by using an approved intrastate funding formula based on these factors: general population aged 60 and older (50 percent); low income population aged 60 and older (30 percent); minority population aged 60 and older (10 percent); and rural population aged 60 and older (10 percent).
- While the division expects the need and total cost for aging services to increase as the number of older adults increases, the division is anticipating level funding. DAAS will continue to actively work with AAAs to maintain the costs for each jurisdiction to within the grant-funded amounts and supplemental funds obtained through other methods.

Section 307(a)(10)

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

RESPONSE:

- The division's Intra-state Funding Formula (IFF) allocates funds in part (10 percent) based on the numbers of older adults residing in rural areas.
- The division requires each service provider to submit a completed DOA-733 form, titled "Methodology to Address Service Needs of Low-Income Minority Elderly and Rural Elderly" annually.
- The division requires each Area Agency on Aging to develop specific service objectives associated with low-income and low-income minority older adults, older adults residing in rural areas, and other populations at risk and with special needs.

Section 307(a)(14)

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

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

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

RESPONSE:

- The division provides state and county profile demographic information and identifies the minority, low-income and limited English proficiency older adults in the state and counties and encourages targeted outreach and delivery of services.
- The division's Aging and Resource Management System (ARMS) captures the profiles of all the clients served in the state. The data collection and analytic team reviews the data for outreach to the minority and low-income and limited English proficiency older adults in the state.
- The division's staff monitoring the AAAs further enforces the outreach to the limited English proficiency older adults in the state and reviews the documents.
- The division has targeted resources to the populations with special needs by using an approved intrastate funding formula based on these factors: general population aged 60 and older (50 percent); low-income population aged 60 and older (30 percent); minority population aged 60 an older (10 percent); and rural population aged 60 and older (10 percent).
- The division requires each AAA to develop specific service objectives associated with low-income and low-income minority older adults and limited English proficiency older adults.
- The AAAs with a higher proportion of limited English proficiency older adults in their areas are cognizant of the cultural and linguistic barriers, and often use bilingual staff and perform targeted outreach with language -specific brochures and encourage participation in services.
- The Equity goal of the 2023-2027 State Aging Services Plan works to enhance outreach and reduce barriers for consumers with limited English proficiency.

Section 307(a)(21)

The plan shall —

. . .

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

RESPONSE:

- The Eastern Band of the Cherokee is the only nationally recognized tribe in North Carolina. The Southwestern Commission Area Agency on Aging (Region A) has a close, working relationship with the Eastern Band of the Cherokee. There are seven tribes recognized by the state.
- The division and AAA reach the tribes and other non-federally recognized tribes through outreach efforts.
- Objective 2 under the Equity goal of the 2023-2027 State Aging Plan outlines how NC will ensure inclusion of diverse cultures and abilities in all aspects of the aging and adult services network. This includes activities with Native Americans.
- The division also provides demographic data on American Indians in each of the 100 counties to AAAs for outreach.

Section 307(a)(27)

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

(B) Such assessment may include—

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

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

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

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

RESPONSE:

- Future projections of the aging population indicate that not all counties in the state will experience growth at the same rate. Some counties will see rapid growth as expanding parts of metropolitan areas, while others will experience moderate growth and few rural counties will experience a decline. A higher proportion of African-Americans live in rural counties and are linked to lower median household income, lower levels of education, higher rates of poverty, and disabilities.
- Compared to urban areas, rural communities often face more unique challenges with transportation options and shortages of healthcare professionals. North Carolina's rural residents continue to face challenges in accessing healthcare, isolation, having higher poverty and mortality rates, and more prevalence of opioid use.
- As described, extra effort will be made toward reducing the waiting list through the possibility of some increased funding and working with agencies to expand their business model to address growth.

- As the population ages, projections are that there will be an increased need for additional services available at the community level. The department strives to work with the NC Division of Health Benefits and the NC Division of Medical Assistance to find new ways of funding supportive programs that allow individuals to remain at home for as long as possible, rather than using the costlier institutional option.
- Population demographics are evaluated annually by the division and AAAs to assure older adults with greatest economic and social needs are served.
- The division conducts needs assessment to determine met and unmet needs in the state.
- The division's Aging and Resource Management System (ARMS) captures the profiles of all the clients served in the state. The data is analyzed to help serve the targeted populations.
- The Intrastate Funding Formula has weights for the targeted populations that aids in funding allocation to those with the greatest social and economic need.
- The programmatic staff that monitors the AAAs enforce this outreach to the targeted populations performed from the regional and state level.
- The 2022 Census data is expected to provide greater information about population growth that should be beneficial in serving the targeted populations.

Section 307(a)(28)

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

RESPONSE:

- The division has an active emergency coordination preparedness program that adheres to both the federal and state mandates.
- The division supports recovery efforts by coordinating with the disaster team and key players to provide annual trainings and assigning and deploying appropriate personnel to assist county departments of social services, Area Agencies on Aging and other local entities as requested.
- The division maintains an updated disaster plan. The purpose of the plan is to define roles and responsibilities within the division and the aging network, including the AAAs, related to planning preparation, response and recovery during all types of disasters. The ultimate mission of the plan is to assure that the special needs of seniors and adults with disabilities are addressed.
- The division developed a continuity of operations plan (COOP). The plan establishes policy and guidance to ensure the execution of mission-essential functions if the agency is threatened or incapacitated, and the relocation of staff is necessary.
- The division staff serve on the statewide disaster preparedness committee and the human services Special Emergency Response Team (SERT), which is directed by the NC Department of Public Safety Emergency Operations Division, along with other human services-related state and local organizations.
- The Long-term Preparedness Planning goal of the 2023-2027 State Aging Plan emphasizes efforts to assist older adults, people with disabilities, and their caregivers with emergency management and disaster preparedness planning, response, and recovery with communication equity:
  - One such way coordination will occur is through collaboration with the AAA's and local emergency response agencies to provide additional support and encourage the expansion of the "call-down" logs systems and other appropriate communication processes to contact those with the highest social and economic needs prior to and following a hurricane and other natural events.
  - We also plan to encourage our AAAs to embed DEI training into their emergency planning work.
- The division plans to assess lessons learned from the COVID-19 pandemic to strategize, develop, and update communication plans, policies, and procedures and continue supporting ongoing COVID-19 response and recovery needs, such as vaccine information and assistance.

- The division requires that the AAAs include comprehensive emergency preparedness and disaster response plans to identify and respond to the needs of older adults in their region that is up to date.
- Each AAA has working relationships with local emergency response agencies, relief organizations, local governments, and/or other institutions responsible for disaster relief service delivery to respond to hurricanes, floods, tornados, and other storms and pandemics professionally and promptly.

Section 307(a)(29)

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

RESPONSE:

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

Section 705(a) ELIGIBILITY —

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

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

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

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

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

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

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

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

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

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

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

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

(ii) receipt of reports of elder abuse;

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

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

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

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

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

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

(iii) upon court order.

RESPONSE:

- The division works closely with, and effectively uses, the opinions of the Governor's Advisory Council on Aging, the Senior Tar Heel Legislature, the NC Coalition on Aging, AARP NC as reflected in the 2023-2027 State Aging Services Plan. These organizations hold public hearings and forums, often in conjunction with DAAS and the AAAs.
- DAAS management is cognizant and respectful of the required assurances referenced in Section 705(a)(7).
- The AAAs are required to develop plans for prevention of elder abuse, neglect, and exploitation in the Area Plans.
- Goal 1 of the 2023-2027 State Aging Services Plan is to ensure the safety and rights of older and vulnerable adults, and prevent their abuse, neglect, and exploitation. The strategies and outcomes related to these goals are related to APS, the Ombudsman program, elder abuse prevention, and partnerships with legal agencies.
- The division conducts on-site program and fiscal monitoring of each AAA and requires the AAAs to submit annual Quality Assurance Reports. Each program has programmatic performance measures that are monitored annually.
- The division monitors each AAA funded activity to ensure compliance with applicable federal requirements and to ensure performance goals are being met.
- The division has protocols in place to ensure that funds are not used to supplant expended under any federal or state law for this subtitle.

C. NORTH CAROLINA INTRASTATE FUNDING FORMULA (IFF)

North Carolina's Intrastate Funding Formula provides funding equitable to ensure quality of services to persons aged 60 and over, including older persons with greatest economic and social needs, low income living in poverty, minority persons and persons residing in rural areas.

1. Funding subject to the Intrastate Funding Formula includes: III-B, III-C1, III-C2, III-E, State Match and State Block Grant Funds.
2. Regional Intrastate Funding Formula elements:
   - 50% Regional 60+/State 60+
   - 30% Regional 60+ Poverty/State 60+ Poverty
   - 10% Regional 60+ Minority/State 60+ Minority
   - 10% Regional 60+ Rural/State 60+ Rural
3. The Intrastate Funding Formula has functioned since SFY 1991. The Formula was reviewed in consultation with Area Agencies on Aging, community service providers, and local elected officials in 2004 to ensure that funding distribution reflected aging demographic trends identified in the 2000 Census. The conclusion of the review study group was that Formula elements should remain unchanged.
4. Intrastate Funding Formula: NC Department of Aging and Adult Services utilizes the following factors to distribute Older American Act funds:

   The current formula provides specific weight for each of the following populations:
   - Persons aged 60 years of age older (50%);
   - Persons aged 60 years and older and who live at or below the Poverty Level (30%);
   - Persons aged 60 years of age and older and are a minority (10%);
   - Persons aged 60 years and older who live in rural areas (10%).

   The mathematical formula used for Title III B, C, D, and E allocations is as follows:

Factor	Weight
Population 60+	50%
Population 60+ in poverty	30%
Population 60+ minority	10%
Population 60+ in rural areas	10%
Total	100%

   Numerical Statement of the Intrastate Funding Formula:
   = (50% X Age 60+) + (30% X Age 60+ living at or below poverty) + (10% X Age 60+ minority) + (10% X Age 60+ living in rural areas)

   Refer the chart under SFY 2024 Planning and Administration for funding formula rates per region.

   NSIP Statement: To allocate federal funding for NSIP, ARMS collects data from the state-mandated OAA reporting system to determine each AAA's previous FFYs meal counts for congregate and home delivered meals. From this data, ARMS calculates each AAA's total meals served in the previous FFY as a proportion of the total meals served in the previous FFY across all AAAs. This determines each AAA's proportion of the overall federal funding allocation for this category for the current allocation.

IFF Population Data Methodology:

Data Sources for Intrastate Funding Formula – The most recent data available is used for IFF formula.

The following funding factors are used in the IFF:

Factor	Description
Population 60+	This factor is the basis for the distribution of funds to the AAA's. It reflects the proportion of persons aged 60 and older. *Data Source: Numbers are extracted from the NC Office of State Budget and Management; Vintage 2021 certified population estimates https://www.osbm.nc.gov/factsfigures*
Population 60+ in Poverty	This factor addresses the social and economic needs of adults 60+ who are living at or below poverty level *Data Source: American Community Survey 2021, five year estimates. Table B17020 Poverty status in the past 12 months by age. https://data.census.gov/. The population factors are updated with the most recent ACS five-year data available to determine the AAA allocations each year.*

Population 60+ minority	This factor addresses the unique social and economic needs of older racial and ethnic minorities in the state. *Data Source: American Community Survey 2021 five-year estimates. Table B01001H Sex by age, white alone, not Hispanic or Latino; Table S0102 population 60 and over https://data.census.gov/. The population factors are updated with the most recent ACS five-year data available to determine the AAA allocations each year.*
Population 60+ in rural areas	This factor addresses the social and economic needs of adults 60+ living in rural areas, especially geographic isolation faced by older North Carolinians. *Data Source: UD Census Bureau's urban-rural classification is used for this factor. The Census Bureau delineates urban areas after each decennial census by applying specified criteria to decennial census and other data. Rural encompasses all population, housing, and territory not included within an urban area. US Census. P12 Sex by age. Urban and Rural https://data.census.gov/. The numbers are updated when the Census Bureau updates the data.*

Disclosure Statement: At this time, there is no disclosure prior to distribution under the IFF to the AAAs for funds deducted from Title III funds for: State Plan Administration, Area Plan Administration, and/or Long-Term Care Ombudsman allocations.

SFY 2024 Planning and Administration

	Federal	State	Total Fed/State
AAA P&A	4,394,897	240,840	4,635,737
P&A State			0
Total	4,394,897	240,840	4,635,737

	Federal	State	Total Fed/State
AAA Support		772,200	772,200

Region	Rate	SFY 2023	SFY 2024 Total	Local Match SFY 2024	Fed AAA P&A	State AAA P & A	Total State/ Fed/Local SFY 2024	State Admin	Total SFY 2024 P&A
A	3.0397%		140,910	37,209	133,589	7,321	178,119	48,262	226,381
B	4.8513%		224,895	59,386	213,211	11,684	284,281	48,262	332,543
C	3.0466%		141,234	37,294	133,896	7,338	178,528	48,262	226,790
D	2.5662%		118,961	31,413	112,781	6,180	150,374	48,262	198,636
E	3.7332%		173,059	45,698	164,068	8,991	218,757	48,262	267,019
F	17.9026%		829,917	219,150	786,800	43,117	1,049,067	48,263	1,097,330
G	17.5274%		812,523	214,557	770,310	42,213	1,027,080	48,262	1,075,342
J	15.2481%		706,860	186,655	670,137	36,723	893,515	48,262	941,777
K	2.9369%		136,146	35,951	129,073	7,073	172,097	48,263	220,360
L	4.0313%		186,880	49,348	177,171	9,709	236,228	48,263	284,491
M	5.0181%		232,628	61,428	220,542	12,086	294,056	48,262	342,318
N	3.6790%		170,550	45,036	161,689	8,861	215,586	48,263	263,849
O	5.1176%		237,240	62,646	224,915	12,325	299,886	48,263	348,149
P	6.1306%		284,199	75,046	269,434	14,765	359,245	48,263	407,508
Q	3.0748%		142,539	37,639	135,134	7,405	180,178	48,263	228,441
R	2.0966%		97,194	25,665	92,144	5,050	122,859	48,263	171,122
Total	**100%**	**-**	**4,635,737**	**1,224,121**	**4,394,894**	**240,841**	**5,859,856**	**772,200**	**6,632,056**

SFY 24 Intra-State Funding Formula

County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	70+*	70+ Formula Rate	60+ Poverty Rates	60+ Minority Rates	60+ Rural Rates
Cherokee	11,354	1,442	749	11,354	17.46%	6,732	16.85%	12.70%	6.60%	100.00%
Clay	4,483	776	85	4,483	7.17%	2,689	6.73%	17.30%	1.90%	100.00%
Graham	2,568	221	139	2,568	3.48%	1,548	3.88%	8.60%	5.40%	100.00%
Haywood	21,216	2,079	849	11,881	27.33%	12,090	30.27%	9.80%	4.00%	56.00%
Jackson	11,492	1,230	1,172	9,653	17.45%	6,559	16.42%	10.70%	10.20%	84.00%
Macon	14,002	1,778	448	11,482	19.96%	8,276	20.72%	12.70%	3.20%	82.00%
Swain	3,766	490	806	3,766	7.15%	2,051	5.13%	13.00%	21.40%	100.00%
Region A	**68,881**	**8,015**	**4,248**	**55,187**	**100.00%**	**39,945**	**100.00%**	**11.82%**	**6.26%**	**81.35%**

County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	70+*	70+ Formula Rate	60+ Poverty Rates	60+ Minority Rates	60+ Rural Rates
Buncombe	76,814	6,836	6,529	19,204	56.20%	40,426	52.58%	8.90%	8.50%	25.00%
Henderson	41,000	2,747	3,116	12,300	27.73%	24,473	31.83%	6.70%	7.60%	30.00%
Madison	6,803	844	313	6,327	6.35%	3,596	4.68%	12.40%	4.60%	93.00%
Transylvania	13,174	1,041	487	8,036	9.72%	8,385	10.91%	7.90%	3.70%	61.00%
Region B	**137,791**	**11,468**	**10,446**	**45,866**	**100.00%**	**76,880**	**100.00%**	**8.49%**	**7.73%**	**33.95%**
Cleveland	26,450	3,703	5,422	14,283	40.29%	13,221	38.59%	14.00%	20.50%	54.00%
McDowell	12,847	1,863	5,653	10,021	22.51%	6,788	19.81%	14.50%	44.00%	78.00%
Polk	7,453	797	2,795	2,310	10.85%	4,411	12.88%	10.70%	37.50%	31.00%
Rutherford	18,187	2,364	1,964	11,276	26.35%	9,840	28.72%	13.00%	10.80%	62.00%
Region C	**64,937**	**8,728**	**15,834**	**37,890**	**100.00%**	**34,260**	**100.00%**	**13.72%**	**24.90%**	**59.58%**
Alleghany	3,755	507	222	3,675	7.18%	2,201	6.59%	13.50%	5.90%	100.00%
Ashe	9,013	847	225	7,437	13.93%	5,074	15.19%	9.40%	2.50%	84.00%
Avery	5,324	564	91	5,035	8.48%	2,926	8.76%	10.60%	1.70%	97.00%
Mitchell	4,679	543	136	3,915	7.81%	2,615	7.83%	11.60%	2.90%	84.00%
Watauga	12,459	1,047	336	9,181	18.55%	6,911	20.69%	8.40%	2.70%	75.00%
Wilkes	19,085	2,290	1,164	13,543	34.26%	10,210	30.57%	12.00%	6.10%	72.00%
Yancey	5,969	579	215	5,955	9.80%	3,465	10.37%	9.70%	3.60%	100.00%
Region D	**60,284**	**6,377**	**2,389**	**48,742**	**100.00%**	**33,402**	**100.00%**	**10.74%**	**4.02%**	**82.07%**
Alexander	10,018	942	701	7,113	10.62%	5,332	10.46%	9.40%	7.00%	71.00%
Burke	25,020	2,527	2,227	10,258	25.59%	13,268	26.02%	10.10%	8.90%	41.00%
Caldwell	22,219	2,289	1,666	7,999	22.25%	11,442	22.44%	10.30%	7.50%	36.00%
Catawba	41,851	3,767	5,064	12,555	41.53%	20,941	41.07%	9.00%	12.10%	30.00%
Region E	**99,108**	**9,524**	**9,658**	**37,925**	**100.00%**	**50,983**	**100.00%**	**9.81%**	**9.95%**	**39.06%**
Anson	5,536	720	2,309	4,097	1.67%	2,931	1.31%	13.00%	41.70%	74.00%
Cabarrus	45,505	3,504	9,283	10,921	9.07%	21,493	9.63%	7.70%	20.40%	24.00%
Gaston	54,070	6,434	8,867	11,355	12.06%	26,349	11.81%	11.90%	16.40%	21.00%
Iredell	45,274	3,396	6,791	18,562	9.50%	21,763	9.75%	7.50%	15.00%	41.00%
Lincoln	23,435	2,625	2,039	11,952	5.64%	11,160	5.00%	11.20%	8.70%	51.00%
Mecklenburg	198,205	16,253	75,913	3,964	38.94%	90,018	40.33%	8.20%	38.30%	2.00%
Rowan	37,782	4,194	6,801	14,735	8.91%	18,551	8.31%	11.10%	18.00%	39.00%
Stanly	16,809	1,916	2,185	11,262	4.38%	8,650	3.88%	11.40%	13.00%	67.00%
Union	48,513	3,202	8,926	17,950	9.82%	22,284	9.98%	6.60%	18.40%	37.00%
Region F	**475,129**	**42,243**	**123,114**	**104,798**	**100.00%**	**223,199**	**100.00%**	**9.20%**	**26.80%**	**22.82%**
Alamance	42,615	4,773	9,759	12,358	9.89%	21,806	10.12%	11.20%	22.90%	29.00%
Caswell	6,816	907	2,542	6,748	2.10%	3,481	1.61%	13.30%	37.30%	99.00%
Davidson	44,006	4,533	5,501	21,563	10.07%	21,930	10.17%	10.30%	12.50%	49.00%
Davie	12,543	1,054	1,304	7,902	2.81%	6,516	3.02%	8.40%	10.40%	63.00%
Forsyth	88,205	9,173	24,433	7,938	19.27%	43,744	20.29%	10.40%	27.70%	9.00%
Guilford	121,450	13,481	39,714	19,432	28.28%	60,191	27.92%	11.10%	32.70%	16.00%
Montgomery	7,414	652	1,468	6,005	1.84%	4,023	1.87%	8.80%	19.80%	81.00%
Randolph	36,739	3,564	3,858	20,941	8.39%	18,631	8.64%	9.70%	10.50%	57.00%
Rockingham	26,310	3,210	5,209	15,786	6.74%	13,348	6.19%	12.20%	19.80%	60.00%
Stokes	13,051	1,449	809	9,919	3.21%	6,528	3.03%	11.10%	6.20%	76.00%
Surry	19,226	2,711	1,461	12,305	4.97%	10,018	4.65%	14.10%	7.60%	64.00%
Yadkin	10,190	999	479	8,458	2.45%	5,339	2.48%	9.80%	4.70%	83.00%
Region G	**428,565**	**46,504**	**96,538**	**149,355**	**100.00%**	**215,555**	**100.00%**	**11.10%**	**23.04%**	**35.65%**
Chatham	24,389	1,610	4,268	14,146	6.28%	15,407	7.63%	6.60%	17.50%	58.00%
Durham	59,290	5,633	25,258	5,336	15.19%	28,265	13.99%	9.50%	42.60%	9.00%

County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	70+*	70+ Formula Rate	60+ Poverty Rates	60+ Minority Rates	60+ Rural Rates
Johnston	44,991	4,724	9,718	24,745	13.28%	20,527	10.16%	10.50%	21.60%	55.00%
Lee	15,275	1,634	3,819	6,874	4.43%	7,846	3.88%	10.70%	25.00%	45.00%
Moore	35,080	2,526	5,157	14,032	8.49%	20,736	10.26%	7.20%	14.70%	40.00%
Orange	32,761	1,998	6,552	13,432	7.78%	15,310	7.58%	6.10%	20.00%	41.00%
Wake	210,028	13,442	57,338	16,802	44.55%	93,967	46.50%	6.40%	27.30%	8.00%
Region J	**421,814**	**31,567**	**112,109**	**95,367**	**100.00%**	**202,058**	**100.00%**	**7.74%**	**27.50%**	**23.40%**
Franklin	18,034	1,353	5,086	15,509	26.32%	8,613	28.28%	7.50%	28.20%	86.00%
Granville	15,654	2,082	5,416	8,766	26.08%	7,401	24.30%	13.30%	34.60%	56.00%
Person	11,044	1,403	3,192	8,062	18.26%	5,506	18.08%	12.70%	28.90%	73.00%
Vance	10,685	1,464	5,033	5,663	18.52%	5,501	18.06%	13.70%	47.10%	53.00%
Warren	5,879	776	3,034	5,879	10.82%	3,438	11.29%	13.20%	51.60%	100.00%
Region K	**61,296**	**7,077**	**21,760**	**43,880**	**100.00%**	**30,459**	**100.00%**	**11.89%**	**36.55%**	**73.70%**
Edgecombe	14,753	2,065	8,306	6,491	18.61%	7,354	18.38%	14.00%	56.30%	44.00%
Halifax	14,773	2,896	7,977	8,716	21.25%	7,462	18.65%	19.60%	54.00%	59.00%
Nash	25,827	3,125	9,633	12,397	30.21%	12,810	32.01%	12.10%	37.30%	48.00%
Northampton	4,610	793	2,411	4,195	6.70%	2,756	6.89%	17.20%	52.30%	91.00%
Wilson	19,234	2,674	7,963	7,694	23.23%	9,632	24.07%	13.90%	41.40%	40.00%
Region L	**79,197**	**11,552**	**36,291**	**39,493**	**100.00%**	**40,014**	**100.00%**	**14.75%**	**46.34%**	**50.43%**
Cumberland	66,108	8,726	32,459	11,899	59.98%	31,034	60.50%	13.20%	49.10%	18.00%
Harnett	26,021	3,331	7,052	15,352	24.82%	12,643	24.65%	12.80%	27.10%	59.00%
Sampson	15,035	1,759	5,758	12,178	15.20%	7,615	14.85%	11.70%	38.30%	81.00%
Region M	**107,164**	**13,816**	**45,269**	**39,430**	**100.00%**	**51,292**	**100.00%**	**13.29%**	**43.54%**	**37.93%**
Bladen	7,428	1,396	2,704	6,611	11.99%	4,130	13.31%	18.80%	36.40%	89.00%
Hoke	8,452	1,420	4,801	4,564	12.95%	3,609	11.63%	16.80%	56.80%	54.00%
Richmond	11,002	1,969	3,301	4,841	15.94%	5,432	17.51%	17.90%	30.00%	44.00%
Robeson	27,169	6,004	17,606	16,301	46.29%	13,269	42.76%	22.10%	64.80%	60.00%
Scotland	8,942	1,395	3,926	3,934	12.83%	4,590	14.79%	15.60%	43.90%	44.00%
Region N	**62,993**	**12,185**	**32,336**	**36,252**	**100.00%**	**31,030**	**100.00%**	**19.47%**	**51.66%**	**57.92%**
Brunswick	57,650	3,344	5,304	21,331	36.19%	31,677	41.30%	5.80%	9.20%	37.00%
Columbus	13,614	1,974	4,343	11,027	14.48%	7,223	9.42%	14.50%	31.90%	81.00%
New Hanover	55,976	4,478	8,620	1,679	35.78%	29,485	38.44%	8.00%	15.40%	3.00%
Pender	16,677	1,434	3,335	10,673	13.56%	8,309	10.83%	8.60%	20.00%	64.00%
Region O	**143,917**	**11,230**	**21,602**	**44,710**	**100.00%**	**76,694**	**100.00%**	**8.11%**	**15.61%**	**32.30%**
Carteret	23,758	1,592	1,782	7,127	12.90%	12,982	17.59%	6.70%	7.50%	30.00%
Craven	25,027	2,277	5,706	7,008	15.66%	13,436	18.20%	9.10%	22.80%	28.00%
Duplin	10,102	939	3,354	8,486	7.52%	5,432	7.36%	9.30%	33.20%	84.00%
Greene	5,080	762	1,869	5,080	4.51%	2,399	3.25%	15.00%	36.80%	100.00%
Jones	2,846	350	1,053	2,846	2.38%	1,433	1.94%	12.30%	37.00%	100.00%
Lenoir	15,708	2,623	6,676	6,126	13.20%	7,898	10.70%	16.70%	42.50%	39.00%
Onslow	29,192	3,328	7,123	10,509	20.05%	13,831	18.74%	11.40%	24.40%	36.00%
Pamlico	4,707	626	857	4,707	3.80%	2,786	3.77%	13.30%	18.20%	100.00%
Wayne	27,413	3,098	10,088	11,788	19.96%	13,616	18.45%	11.30%	36.80%	43.00%
Region P	**143,833**	**15,596**	**38,508**	**63,676**	**100.00%**	**73,813**	**100.00%**	**11.05%**	**27.29%**	**45.13%**
Beaufort	14,709	1,912	3,368	10,149	22.76%	8,292	24.97%	13.00%	22.90%	69.00%
Bertie	4,691	666	2,716	3,940	8.33%	2,404	7.24%	14.20%	57.90%	84.00%
Hertford	5,502	655	3,197	3,741	9.04%	2,743	8.26%	11.90%	58.10%	68.00%
Martin	7,279	1,055	3,203	5,678	12.48%	3,744	11.28%	14.50%	44.00%	78.00%

County	60+ (50%)	60+ Poverty (30%)	60+ Minority (10%)	Rural (10%)	IFF Formula Rate (100%)	70+*	70+ Formula Rate	60+ Poverty Rates	60+ Minority Rates	60+ Rural Rates
Pitt	33,701	3,606	12,638	10,447	47.39%	16,022	48.25%	10.70%	37.50%	31.00%
Region Q	**65,882**	**7,894**	**25,122**	**33,956**	**100.00%**	**33,205**	**100.00%**	**12.08%**	**38.45%**	**51.97%**
Camden	2,678	134	544	2,624	4.86%	1,269	5.03%	5.00%	20.30%	98.00%
Chowan	4,407	573	1,525	2,953	10.51%	2,502	9.93%	13.00%	34.60%	67.00%
Currituck	7,471	471	770	7,322	13.59%	3,272	12.98%	6.30%	10.30%	98.00%
Dare	11,802	484	791	3,541	16.92%	5,941	23.57%	4.10%	6.70%	30.00%
Gates	3,093	520	1,222	3,093	8.62%	1,603	6.36%	16.80%	39.50%	100.00%
Hyde	1,386	125	539	1,386	3.12%	685	2.72%	9.00%	38.90%	100.00%
Pasquotank	9,372	1,068	3,533	3,843	20.85%	4,549	18.05%	11.40%	37.70%	41.00%
Perquimans	4,705	423	1,035	4,705	9.92%	2,800	11.11%	9.00%	22.00%	100.00%
Tyrrell	1,003	83	333	1,003	2.16%	577	2.29%	8.30%	33.20%	100.00%
Washington	3,722	529	1,593	2,568	9.46%	2,011	7.98%	14.20%	42.80%	69.00%
Region R	**49,639**	**4,409**	**11,884**	**33,037**	**100.00%**	**25,209**	**100.00%**	**9.14%**	**24.63%**	**68.46%**
N C	**2,470,430**	**248,185**	**607,107**	**909,565**		**1,237,998**		**10.31%**	**25.23%**	**37.80%**

SFY 2024 Ombudsman Funding Formula (INPUTS UPDATED 03/30/2023)

Region	LTC BEDS	LTC Bed Share	70% Weight LTC BEDS	Advisory Committees	Ad. Comm. Share	20% Weight Adv. Comm.	Sq. Miles	Sq. Mile Region Share	10% Weight Sq. Miles	Ombudsman Formula share
A	2,229	2.4984%	1.7489%	8	5.3333%	1.07%	3052.00	5.72%	0.5717%	3.3873%
B	5,376	6.0258%	4.2181%	5	3.3333%	0.67%	1857.00	3.48%	0.3479%	5.2326%
C	2,905	3.2561%	2.2793%	7	4.6667%	0.93%	1708.00	3.20%	0.3200%	3.5326%
D	2,050	2.2978%	1.6085%	9	6.0000%	1.20%	2512.00	4.71%	0.4706%	3.2790%
E	3,612	4.0486%	2.8340%	6	4.0000%	0.80%	1639.00	3.07%	0.3070%	3.9411%
F	17,018	19.0751%	13.3525%	16	10.6667%	2.13%	4195.00	7.86%	0.7859%	16.2717%
G	17,079	19.1434%	13.4004%	18	12.0000%	2.40%	5909.00	11.07%	1.1070%	16.9074%
J	13,866	15.5421%	10.8794%	10	6.6667%	1.33%	3953.00	7.41%	0.7405%	12.9533%
K	1,909	2.1398%	1.4978%	10	6.6667%	1.33%	2098.00	3.93%	0.3930%	3.2242%
L	3,251	3.6440%	2.5508%	9	6.0000%	1.20%	2677.00	5.01%	0.5015%	4.2523%
M	3,711	4.1596%	2.9117%	6	4.0000%	0.80%	2194.00	4.11%	0.4110%	4.1227%
N	2,408	2.6991%	1.8893%	9	6.0000%	1.20%	3007.00	5.63%	0.5633%	3.6527%
O	4,032	4.5194%	3.1636%	5	3.3333%	0.67%	3265.00	6.12%	0.6117%	4.4419%
P	5,385	6.0359%	4.2251%	13	8.6667%	1.73%	6103.00	11.43%	1.1433%	7.1018%
Q	2,580	2.8919%	2.0243%	7	4.6667%	0.93%	3175.00	5.95%	0.5948%	3.5524%
R	1,805	2.0232%	1.4162%	12	8.0000%	1.60%	6036.00	11.31%	1.1308%	4.1470%
TOTAL	**89,216**	**100.0000%**	**70.0000%**	**150**	**100.0000%**	**20.00%**	**53380.00**	**100.00%**	**10.0000%**	**100.0000%**

D. STATE AGING PLAN GOALS - PERFORMANCE MEASURES AND EXPECTED OUTCOMES

GOAL 1: Use policy, advocacy, education, and a multi-disciplinary approach to protect the rights of Older North Carolinians from abuse, neglect, and exploitation.

OBJECTIVE 1.1: Training and outreach regarding the protection of vulnerable older adults and indicators of maltreatment and guardianship resources will be provided to community stakeholders.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Partner with stakeholders in the development of training and informational materials targeted to older adults, people with disabilities, and their caregivers.	▪ Annually, establish at least two non-traditional partners to collaborate training and outreach materials. ▪ Annually, track the number of requests and copies of the training and information materials.
Strategy 2: Improve training opportunities for the aging and adult services workforce by engaging with entities such as the University of North Carolina (UNC) Cares at the School of Social Work at Chapel Hill, to evaluate NC's existing workforce training curriculum.	▪ By the end of June 2024, conduct a cross-analysis of existing training curriculums in NC and other states to improve training and collaborative opportunities.
Strategy 3: In collaboration with The Division of Social Services (DSS) Adult Protective Services (APS) systems, share data with law enforcement and others who have contact with individuals found to be self-neglecting.	▪ By June 2025, develop and implement a system for sharing data with law enforcement to improve coordination and identify and promote a tool specifically designed for law enforcement and other First Responders who encounter frail and/or disabled older adult victims of abuse.
Strategy 4: Develop a financial exploitation training for NC District Attorneys and law enforcement and invite DSS county staff to participate in District Attorney-led trainings.	▪ By June 2024, evaluate the current training curriculum on financial exploitation and analyze the original Money Smart Training to develop a financial exploitation training for NC District Attorneys and law enforcement. ▪ Semi-annually, conduct a multi-agency financial exploitation training, inviting NC District Attorneys and law enforcement, to address the complexities of abuse and methods to effectively respond; administer survey to determine effectiveness of training in order to evaluate training content after every training.
Strategy 5: In partnership with DIT, create a database for Adult Protective Services Register (APS-R) and Disinterested Public Agent Guardians (DPAG) systems to work toward standardization of the program and modernization of service delivery standards and reporting mechanism.	▪ By 2025, transition to DPAG system, update user-manual and provide training to staff on the new system's purpose, functions, and instructions.
Strategy 6: In partnership with county DSS and APS Improvement Design Team, develop communication plans for educating the public on abuse, neglect, and exploitation.	▪ By June 2025, ensure all 100 counties have a communication distribution communication plan for the customizable brochure and track distribution through Adult Services tracking log. ▪ Annually, Increase the number of professionals reporting abuse, neglect, and exploitation of vulnerable adults by 5% each year.

Strategy 7: In partnership with the UNC School of Social Work, develop LGBTQ+ and HIV + inclusive client rights and responsibilities to be issued to recipients of care in all settings and made publicly available online.	▪ By June 2024, administer survey to assess the number of providers and organizations that have integrated LGBTQ+ and HIV+ inclusive client rights and responsibility guidelines into their policies and procedures. ▪ By December 2024, update website to include clear guidelines for LGBTQ+ and HIV+ inclusive client rights and responsibilities.
Strategy 8: In collaboration with Division of Services for Deaf and Hard of Hearing (DSDHH), provide training on working with Deaf, Hard of Hearing, and DeafBlind older adults.	▪ By June 2024, collaborate with DSDHH to develop a comprehensive and engaging training program offered to at least 4 AAA regions every year. ▪ Annually, track and document the number or provider and aging professionals who attend DSDHH training that will focus on improving the ability of providers to effectively communicate with and provide quality care to Deaf, Hard of Hearing, and DeafBlind older adults.

OBJECTIVE 1.2: Advocate for the advancement of Adult Protective Services (APS) transformation work in partnership with county DSS and key program stakeholders to advance innovative solutions that foster and promote safety, independence, and the improvement of health and well-being for vulnerable adults served by APS.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Implement APS Improvement Plan through the establishment of the three design team workgroups.	▪ By 2027, complete work highlighted in the APS Improvement Plan through the three workgroups established in January 2023.

OBJECTIVE 1.3: Through training and outreach, long-term care residents and those who care for and support those residents will understand and be better equipped to assist and empower their rights.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Through written communication, provide encouragement on the inclusion of the Residents' Bill of Rights in the admissions documents given to residents and/or their legal representatives.	▪ By June 2024, survey facilities and a sample of residents on if resident rights are included in admission packets. ▪ By January 2025, query a sample of facilities on whether resident rights are included on admission packets after communication has been provided using survey analysis.
Strategy 2: Facilitate resident's rights trainings in community forums and long-term care settings and offer new educational trainings to residents/families on long-term care services to increase awareness of Ombudsman program.	▪ By June 2024, in target regions, conduct the resident's rights training in community forums and long-term care settings and conduct pre-and post- training surveys to assess changes in residents'/families' awareness. ▪ By June 2025, based on feedback from attendees at community forums and long-term care settings, develop and offer new education trainings.

Strategy 3: The legal services developer will continue building and fostering partnerships with legal service providers throughout the state to ensure underserved and underrepresented communities have access to information enabling them to make informed decisions. **Sub-strategy 3:** Provide training to NC residents regarding legal rights as it relates to the priority legal services.	▪ Annually, track the number of trainings conducted by the legal services developer and the legal services provider on priority legal services as defined by the Older Americans Act and report number of trainings offered and number of attendees. ▪ Annually, track the number of presentations conducted in underserved/underrepresented communities by legal service providers and AAAs which foster awareness of elder law issues in their communities. ▪ Annually, track the number of persons served with legal services to establish a baseline and develop additional programming based on the results.
Strategy 4: Continue support of the Rethinking Guardianship Initiative to improve NC's system of rights and protections for individuals who need support and assistance with decision-making.	▪ Annually, participate in ongoing Rethinking Guardianship meetings and report back to DAAS leadership team. ▪ By June 2025, incorporate alternatives to guardianship into training provided by Adult Services Section.
Strategy 5: Implement work from Strategic Alliances for Elders in Long-Term Care (SAFE in LTC) taskforce, Investigating Crimes in Long-term Care Facilities: Voiceless Victims Curriculum, to strengthen the relationship between law enforcement and aging professionals.	▪ Annually, conduct 4 sessions of the Investigating Crimes in Long Term Care Facilities: Voiceless Victims Course at the NC Justice Academy and administer pre-surveys to determine baseline knowledge and effectiveness and post-course utilization through the Long-Term Care Ombudsman Program.
Strategy 6: Enhance standards for Community Advisory Council (CAC) volunteers through new Administration for Community Living (ACL) Training standards.	▪ By June 2025, in partnership with the AAAs, implement standards with the 10 modules for CAC volunteers across all NC counties.
Strategy 7: Continue working with appropriate regulatory agencies and referring individuals to such agencies when resolutions of concerns or grievances are not possible through the Long-Term Care Ombudsman Program.	▪ Annually, track the number of referrals made to other agencies.
Strategy 8: Collaborate with DSDHH to provide training to Ombudsman to improve their ability to serve the Deaf, Hard of Hearing, and DeafBlind aging community. Partner with DSDHH to provide training to residents and caregivers to improve their self-advocacy skills, knowledge of communication access rights and where they can find additional assistance and resources.	▪ Semi-annually, provide training to Ombudsman on accessibility and communication access.
Strategy 9: Provide training on LGBTQ+ and HIV+ rights and protections to aging service providers and staff of long-term care facilities in partnership with the State Long Term Care Ombudsman Program, Legal Assistance providers, and LGBTQ+ and HIV+ organizations.	▪ By June 2025, in collaboration with SAGE USA and Carolina aging Alliance, provide training on LGBTQ+ and HIV+ rights and protection to all 16 AAAs and provide resources to disseminate in the region.
Strategy 10: DAAS will sustain relationship with transitions coordinators and support the Transition to Community Initiative to ensure those in LTC residences are aware of, and have access to, independent living options in the community.	▪ Annually, disseminate brochure on independent living options to LTC facilities.

OBJECTIVE 1.4: Through building and maintaining strong relationships with key stakeholders and advocacy organizations, advance advocacy efforts and increase awareness and support for policies and programs that promote healthy aging.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Establish robust quality assurance mechanisms into P and A monitoring and continue to collaborate with AAAs to strengthen recruitment efforts.	▪ Annually, track the number of new and qualified STHL appointed through the enhanced recruitment efforts and updated quality assurance and track the number of P and A monitoring measures established to ensure quality assurance of STHL appointees.
Strategy 2: Provide advocacy groups, such as the STHL and GAC, with timely and relevant information, training, and continuing education regarding pertinent aging issues, empowering them to stay abreast of developments and enabling them to advocate more effectively.	▪ By December 2023, survey advocacy groups to establish baseline percentage of advocacy group members who report feeling well-informed and confident in their ability to advocate for aging issues. ▪ Annually, provide up-to-date information on developments and emerging issues related to aging through established communication methods. ▪ Annually, provide support to advocacy groups in developing priorities in their promotion of citizen involvement and advocacy concerning aging issues.

GOAL 1 EXPECTED OUTCOMES	
OBJECTIVE 1	▪ Increased awareness and understanding of elder abuse and neglect among community stakeholders. ▪ Improved identification and reporting of elder abuse and neglect cases by community stakeholders. ▪ Increased access to guardianship resources and support for vulnerable older adults. ▪ Increased awareness, knowledge, and skill-level, regarding the recognition and reporting of abuse, neglect and exploitation of older adults to stakeholders and other organizations, and people that encounter older adults. ▪ Updated APS database to standardize and modernize services and include SOGI data elements.
OBJECTIVE 2	▪ Improved outcomes for vulnerable adults served by APS, including increased safety, independence, and health and wellbeing. ▪ Increased capacity of APS to serve vulnerable adults through innovative solutions and approaches. — Improved services and supports to NC's elderly and vulnerable adults through research, documenting gaps and recommendations, and presentations to APS Leadership Team. — Development of county-centered approach to promote local buy-in and accountability for a joint CQI process. ▪ Improved partnerships and collaboration between APS and community stakeholders. — Strengthened and improved APS, through consistency of practice, community stakeholder engagement, community education, and APS statutory improvements. — Collaboration with various stakeholders within and across NC counties through APS System Improvement Design Teams. — Increased MTDs across the state.

OBJECTIVE 3	• Improved knowledge and understanding of residents' rights among long-term care residents and their caregivers. • Increased awareness, knowledge, and skill-level, regarding preserving and respecting the rights of individuals in long-term care settings. • Improved advocacy for residents' rights and protections by long-term care staff and caregivers. • Enhanced quality of life for long-term care residents through improved empowerment and support of their rights. • Implementation of standards for Community Advisory Council (CAC) volunteers across all NC counties. • Strengthened relationship between law enforcement and aging professionals. • Increase capacity of Ombudsman and long-term care facility staff to serve and advocate for Deaf, Hard of Hearing, and DeafBlind older adults. • Increased communication access for Deaf, Hard of Hearing, DeafBlind older adults receiving services and living in long-term care facilities.
OBJECTIVE 4	• Increased number of qualified STHL appointed, leading to improved quality of care provided to older adults. • Higher percentage of STHL appointees meeting the minimum standards for membership. • Increased commitment of STHLs to serving and meeting established baseline expectations. • Higher confidence among advocacy group members in their ability to advocate for aging issues. • More successful advocacy outcomes achieved as a result of enhanced training and education initiatives. • Greater satisfaction of advocacy groups with the information and training provided.

GOAL 2: Support programs and partnerships that improve the health and well-being of older North Carolinians.

OBJECTIVE 2.1: Through an interdisciplinary approach, DHHS and community partners will employ system and community level strategies to meet the food and nutrition security needs of older adults, increase their access to nutritious foods, and promote healthy eating habits.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Collaborate with key stakeholders in NCDHHS to build connections between the Senior Nutrition Program and other NCDHHS nutrition security supports, including Food and Nutrition Services (FNS), NC Medicaid and the Healthy Opportunities Pilots, NCCARE360, and others.	• By June 2024, develop a plan with state partners to report and distribute food benefit participation rates to regional and local partners helping to target eligible seniors.
Strategy 2: Collaborate with regional Area Agencies on Aging (AAAs) to encourage local community service providers to join NCDHHS' FNS benefits marketing campaign by sharing best practices about FNS benefits outreach and messaging.	• Annually as needed, distribute baseline participation rates in FNS and/or SNAP as well as periodic updates on participation within the region and counties.

Strategy 3: Enhance the capacity of local community service providers to connect at-risk older adults with food benefits programs by conducting outreach and arranging educational programs to teach their seniors about eligibility and how to apply.	▪ Annually, track the number of staff at the Annual Nutrition Program Management Training (including both community service providers and AAA staff) and the number of presentations at the Annual Nutrition Program Management Training about outreach and targeting of food benefits information to eligible clients; after each training, conduct post-training evaluations to assess effectiveness of presentations.
Strategy 4: Help the aging network rebuild post-pandemic and strengthen its ability to provide a range of nutrition services using innovative strategies and diverse funding sources.	▪ By December 2023, develop standard informational interview questions to ask each AAA director and conduct informational interviews with each AAA region director/aging specialist(s) about the status of the Senior Nutrition Program (pre-pandemic, during pandemic, post-pandemic, and future plans) in their region. ▪ By June 2024, develop a status report on pandemic operations, service delivery, and plans for rebuilding the Senior Nutrition Program post-pandemic.
Strategy 5: Create new Senior Nutrition Program training opportunities for AAAs based on needs and/or challenges identified by AAAs.	▪ Annually, track the number of presentations delivered to AAAs and nutrition program staff on topics requested from the informational interviews, such as medically tailored meals, screening and referral, and outreach to targeted populations across funding sources.
Strategy 6: Grow the reach of the Senior Farmers' Market Nutrition Program by increasing the number of eligible older adults participating, the number of farmers' markets and farmers accepting coupons, and the coupon redemption rate.	▪ Annually, track additional funding secured for the Seniors Farmers' Market Nutrition Program (SFMNP) and the number of new partnerships or collaborations established with organizations that can provide additional funding. ▪ Annually, maintain a redemption rate of at least 80% for the SFMNP. ▪ Annually, track the number of farmers markets certified and accepting coupons.
Strategy 7: Support the Governor's Advisory Council on Aging (GAC) in convening a NC Senior Hunger Summit to help identify and evaluate the efficiency and effectiveness of the current nutrition services landscape for North Carolina's older adults.	▪ By 2027, based on the number of new action steps identified from the NC Senior Hunger Summit, measure implemented action steps.

OBJECTIVE 2.2: Continue to improve transportation for older adults by supporting a more responsive, coordinated, diverse, and inclusive transportation system.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Seek opportunities to collaborate with NCCARE360 and NC211 to increase referrals by the aging network to transportation resources.	▪ By June 2024, track the number of and types of referrals made by the aging network to transportation resources identified in NCCARE360 and NC211. ▪ By January 2024, share an updated HCCBG funded provider list with NC 211 data resource staff so that call center staff can make the most accurate referrals (In Fiscal Year 2022, there were 254 HCCBG providers). ▪ By June 2024, conduct 2 meetings with AAAs focused on encouraging providers to become a user of NCCARE360 through their business acumen work.
Strategy 2: In partnership with the Older Driver Workgroup of the NC Governor's Highway Safety Program, continue expanding public awareness of driver safety resources and promote safe driving among older adults.	▪ Annually, participate in the Older Driver Workgroup and provide updates to DAAS leadership.
Strategy 3: Provide education about general and medical transportation options to older adults and people with disabilities through community services and supports.	▪ By June 2024, develop outreach materials and disseminate to aging professionals and community organizations. ▪ Annually, utilize wait list information to target regions where enhanced transportation is needed and work with AAAs to enhance transportation options. ▪ Annually, track number of referrals.
Strategy 4: In partnership with DSDHH, ensure all aspects of communicating transportation information and the transportation system is accessible for people with hearing loss.	▪ Annually, host a minimum of one educational meeting on accessibility and transportation systems with county planning entities collaborating with AAAs. ▪ By June 2025, work with transportation providers to conduct a survey to analyze the number of accessible transportation options provided across the state; by June 2026, provide report on accessibility needs met through transportation services for people with disabilities and other groups with accessibility needs.

OBJECTIVE 2.3: Older adults will have access to evidence-based health promotion, wellness, and disease prevention programs.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: In collaboration with Healthy Aging NC (HANC), research best practices for educating communities about evidence-based health promotion and disease prevention (EBHP/DP) programs.	▪ By December 2024, track the number of best practices identified and documented. ▪ Annually, conduct quarterly calls with AAA regional coordinators and partners focused around sharing best practices and strategizing ways to increase participation, with the goal of 80% program completion rates.

Strategy 2: Continue working with the AAAs and senior centers in expanding, offering, and promoting EBHP/DP programs.	▪ By 2027, establish at least two new partnerships to promote healthy aging programs. ▪ Annually, enroll an average 5,000 participants every year (In Fiscal Year 2022, there were 5,500 participants). ▪ Annually, regional and local evidence-based health promotion programs will increase the number of participants enrolled by 10% each year statewide and utilize the Mon Ami software to establish baselines of unduplicated participants. ▪ By December 2024, develop and disseminate a unified statewide survey that looks at participant satisfaction.
Strategy 3: Review the monitoring tool for evidence-based programs to ensure that programs are delivered in accordance with federal requirements.	▪ By June 2025, complete analysis of federal requirements to inform revision of monitoring tools and evaluate the number of programs found to be in compliance with federal requirements. ▪ Collaborate with state and local partners to streamline referrals.
Strategy 4: Partner with HANC to provide technical assistance to the AAAs in the development of a sustainability plan for EBHP/DP programs, including opportunities for contracting with healthcare payers.	▪ By January 2025, complete program evaluation and sustainability plan for EBHP/DP programs. ▪ Annually, track the number of AAAs that have successfully contracted with healthcare payers for EBHP/DP programs.
Strategy 5: Train the AAAs, and reinforce through monitoring, expectations regarding evidence-based program data reporting.	▪ Semi-annually, provide training to all 16 AAAs on data reporting expectations; administer pre-and post-survey on accuracy and completeness of data reports.
Strategy 6: Measure effectiveness of the NC Senior Games as a year-round physical and mental health promotion program.	▪ Annually, 80% of Senior Games participants will rate their present health 'excellent' or 'very good', compared to others their age on BRFSS.

OBJECTIVE 2.4: Maintain a statewide structure to coordinate falls reduction efforts.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Continue implementation of the current 2021-2025 Falls Prevention Action Plan and participate in the development of the 2026-2030 plan.	▪ By June 2026, analyze the number of action items successfully implemented/completed from the 2021-2025 plan. ▪ By June 2025, track new partners involved in the development of the 2026-2030 plan.
Strategy 2: Collaborate with the NC Falls Prevention Coalition to support annual summits to promote evidence-based and evidence-informed strategies for falls prevention.	▪ Annually, increase participation in NCFPC summits by 5% every year.
Strategy 3: Advance clinical-community integration through the NCFPC's referrals pathways workgroup and explore ways to integrate falls prevention referrals into electronic health records (EHR).	▪ By January 2025 and annually thereafter, track the percentage of healthcare providers who use EHR and include falls prevention referrals. ▪ By January 2025 and annually thereafter, track the number of referrals made through EHR for falls prevention programs to establish baseline measures.

Strategy 4: In partnership with NC research institutions, develop screening for fall-related TBI.	▪ By 2027, develop a screening for fall related TBI and incorporate TBI screenings into routine healthcare assessments, such as the annual wellness visits.
Strategy 5: Explore how DAAS, Division of Public Health (DPH), Division of Mental Health/Developmental Disabilities/ Substance Abuse Services (DMH/DD/SAS), and the Division of Vocational Rehabilitation Services (DVRS) can work with NCFPC to form partnerships with brain injury organizations to educate healthcare providers about screening and referrals for brain injury in older adults.	▪ Annually, form a minimum of two partnerships to educate providers about the importance of screening and referrals for brain injury in older adults.
Strategy 6: Work with the NCFPC and aging and disability service providers to increase access to evidence-based and evidence-informed falls prevention programs and education across all counties.	▪ By 2025, connect all 100 counties to falls prevention efforts.
Strategy 7: Develop and promote falls prevention strategies in the State Health Improvement Plan (SHIP) to address drivers that impact health outcomes.	▪ By 2027, track progress on indicators from the 2023 plan.
Strategy 8: Educate older adults, healthcare providers, and long-term care facilities on the importance of annual comprehensive hearing evaluations to promote the detection of hearing loss and its connection to falls, dementia, depression and isolation, diabetes, cardiovascular disease, and kidney disease.	▪ Annually, track the number of outreach materials developed and shared with healthcare providers to educate their patients about hearing loss and falls.

OBJECTIVE 2.5: Expand public awareness regarding the benefits of senior centers and their role in the community.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Provide education and training to senior centers to support their programming, including multigenerational components and inclusivity for historically marginalized and underserved populations.	▪ Annually, provide four hours of senior center staff training to enhance staff understanding of service delivery and encourage programming which offers participants access to exceptional educational, wellness, and evidence-based activities, via the senior center certification training and/or the Ann Johnson Institute for Senior Center Management. ▪ Annually, provide training opportunities to enhance the professional skills of senior center staff, through the Senior Center Leadership Symposium.
Strategy 2: Support the NC Senior Center Alliance in the promotion of senior centers and advocacy efforts.	▪ Annually, participate in ongoing NC Senior Center Alliance meetings and provide any guidance to help assure statewide coordination of the three advocacy events per year. ▪ Annually, track the number of senior centers participating as members of the NC Senior Center Alliance (In Fiscal Year 2022, there were 70 NCCOA members, with 55 directly from senior centers).

Strategy 3: Provide training to senior centers on existing outreach materials.	▪ By December 2024, complete Senior Center Outcomes Survey data to develop best practices for marketing and training materials to increase senior centers' publicity. ▪ By June 2025, analyze data to improve existing materials.
Strategy 4: Collaborate with AAAs and representatives from senior centers to evaluate and strengthen the senior center certification program.	▪ By December 2026, update the senior center certification program.

OBJECTIVE 2.6: Increase public awareness of mental health challenges and disorders and strengthen social connection systems to mitigate the effects of social isolation, loneliness, and elevated suicide risk.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Collaborate with Geriatric Adult Mental Health Specialty Teams (GAST) to provide training in mental health and substance use issues and provide support to people working with older adults living in the community.	▪ By December 2023, reestablish partnership with GAST and provide annual updates to DAAS leadership. ▪ By January 2024 and annually therefore, track the number of people working with older adults in the community trained in mental health and substance use issues and the improvement in their ability to identify and respond to mental health and substance use issues among older adults, measured through surveys.
Strategy 2: Work with DMH/DD/SAS and Office of Communications (OoC) to host a series of live aging and mental health talk-ins where older adults and caregivers are invited to share questions, concerns, and needs and learn about resources to improve mental well-being.	▪ Annually, host 3 aging and mental health talk-ins across the state.
Strategy 3: Work with DMH/DD/SAS to promote mental health services and educate older adults with severe mental illnesses/severe persistent mental illnesses (SMI/SPMI) about the Transitions to Community Living (TCL) Initiative.	▪ Annually, track the number of outreach informational materials disseminated to older adults about mental health services offered by DMH.
Strategy 4: Partner with stakeholders in the development of training and informational materials about drug use, abuse, and misuse to older adults, people with disabilities, and their caregivers.	▪ Annually, track the number of materials developed and disseminated about drug use, abuse, and misuse.
Strategy 5: Explore opportunities to expand B.E. With and ASIST trainings to aging service providers and other DHHS partners to address social isolation, loneliness, and elevated suicide risk among older adults.	▪ By June 2024, expand of the B.E. With and ASIST trainings to aging service providers and other DHHS partners. ▪ Annually, track reported improvement in social isolation, loneliness, and suicide risk among older adults to establish baseline metrics.
Strategy 6: Incorporate screening for social isolation and referrals to social engagement programs into the information and referral activities, including NCCARE360.	▪ Annually, track the number of people screened and referred to social engagement programs and establish baseline.
Strategy 7: Continue to partner with the NCCHW to expand the Social Bridging Project to support social connectedness for older adults in all areas of North Carolina.	▪ By 2027, expand Social Bridging Project to all areas of NC and track the number of older adults who receive support through the project and any reported improvement in social connectedness.

Strategy 8: Provide training to senior center staff and aging and disability services providers on identifying and addressing social isolation among those identified as being at risk.	▪ Annually, track the number of educational meetings conducted on identifying and addressing social isolation.
Strategy 9: Partner with DSDHH to ensure older adults with hearing loss have access to assistive technology and address the correlation between hearing loss and social isolation.	▪ Annually, track the number of outreach informational materials provided to older adults about hearing loss and social isolation in the community.

GOAL 2 EXPECTED OUTCOMES	
OBJECTIVE 1 (Nutrition)	▪ Increased access to nutritious foods for older adults, leading to improved nutritional health outcomes and reduced food insecurity among older adults receiving OAA services. — Increased services to people with highest needs and increased participation rates in nutrition programs that address special dietary needs, cultural considerations, and medically tailored options. — increased number of applications to food assistance programs. ▪ Increased awareness of the importance of healthy eating habits among older adults, leading to better dietary choices and improved health outcomes. — Increased knowledge of malnutrition, its impact, prevention, treatment, and available resources. ▪ Development of a coordinated food and nutrition security system for older adults, leading to more efficient and effective delivery of services and resources.
OBJECTIVE 2 (Transportation)	▪ Improved transportation options for older adults, leading to increased mobility and social connectedness. — Expansion of consumer-directed transportation programs to support client choice. ▪ Enhanced coordination between transportation providers and community organizations, leading to more efficient and effective transportation services. — Increased referrals by the aging network to transportation resources. — Increased partnerships with aging and disability providers to expand transportation options and resources. ▪ Increased accessibility and inclusivity of transportation services for older adults, leading to improved quality of life and independence.
OBJECTIVE 3 (Evidence-based health promotion and disease prevention)	▪ Increased number of older adults and adults with disabilities participating in evidence-based health promotion and disease prevention programs, leading to increased quality of life and improved health outcomes. ▪ Increased awareness and utilization of evidence-based health promotion and disease prevention programs among older adults, leading to improved health literacy and better health outcomes. ▪ Development of a comprehensive and coordinated system for delivering health promotion and disease prevention programs to older adults, leading to more efficient and effective delivery of services and resources. ▪ Increased number of older adults that report that they were able to participate in evidence-based health promotion and disease prevention programs because of access to communication (ASL Interpreters or Captioning or Amplification Device or Other Accommodation if requested).

OBJECTIVE 4 (Falls prevention)	• Reduced incidence of falls and decreased falls injury deaths, hospitalization, and ED visits among older adults, leading to improved health outcomes. • Enhanced coordination and collaboration among stakeholders involved in falls prevention efforts, leading to a more efficient and effective falls prevention efforts. • Increased awareness and utilization of falls prevention strategies and resources among older adults, leading to improved health outcomes and quality of life. • Increased understanding of the multifactorial aspect of falls and the importance of addressing physical activity, home modification, medication management, and other risk factors with falls prevention programming. • Integration of falls prevention referrals into electronic health records (EHR). • Increased healthcare provider knowledge about screening and referrals for brain injury in older adults.
OBJECTIVE 5 (Senior Center)	• Increased utilization of senior centers, leading to improved social connectedness, engagement, and quality of life for older adults. • Increased awareness and knowledge among the public of the important role that senior centers play in supporting older adults and the community, leading to increased investment and support for senior center programs and services. • Enhanced collaboration and coordination among senior centers and community organizations, leading to more comprehensive and effective service delivery to older adults. • Strengthened senior center certification program.
OBJECTIVE 6 (Mental Health/ Social Isolation)	• Increased awareness and recognition of mental health challenges and disorders, social isolation, and stigmas among older adults, caregivers, professionals, and the general public, leading to improved mental health outcomes and reduced stigma. • Increased availability and accessibility of mental health services and resources for older adults, leading to improved mental health outcomes and quality of life. — Increased dissemination of resources to improve mental well-being. • Enhanced social connection systems, leading to reduced social isolation and loneliness among older adults and a reduced risk of suicide and other adverse mental health outcomes. • Increased awareness and recognition of hearing loss on mental health, social isolation, and stigmas among older adults, caregivers, professionals, and the general public, leading to improved accessibility to resources that can enhance the quality of life and assist with these challenges.

Goal 3: Adopt an equity-centered housing lens approach to enable older adults to age in their place of choice with the appropriate services, supports, and housing opportunities.

OBJECTIVE 3.1: Promote expansion of home and community-based services to support older adults aging in the least restrictive setting and provide aging-in-place housing improvements.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Utilize HCCBG and Rapid Rehousing funds to fund home modifications and repair (HMR) for older adults.	• Annually, track HCCBG and Rapid Rehousing funds used for HMR.
Strategy 2: In partnership with the Independent Living Rehabilitation Program, address the barriers to home modification access and service delivery by increasing the availability and awareness of home modification at the state and local levels.	• Annually, track the number of state resources on home modifications created and disseminated.

Strategy 3: Increase awareness of housing and home improvement services and promote mobility and accessibility services as a means of keeping people safe in their home.	▪ Annually, Increase the number of service providers and people served (In State Fiscal Year 2022: 1,567 people were served).
Strategy 4: Work with the AAAs to encourage Housing and Home Improvement (HHI) providers to use a Prioritization tool as best practice in the management of HHI waitlist.	▪ Annually, track the number of educational sessions offered about the benefits of using a Prioritization tool to manage HHI waitlist to the 16 AAA and their HHI providers.
Strategy 5: Support adults of all ages to transition from facilities to home and community settings through the Money Follows the Person (MFP) Demonstration Grant.	▪ Annually, increase the number of individuals transitioned.

OBJECTIVE 3.2: Increase affordable housing opportunities, provide permanent supportive housing (PSH), and support a coordinated, comprehensive system of services to address, prevent, reduce, and end chronic homelessness among older adults.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Utilize funds to help support eviction prevention to include emergency rent assistance, tenancy supports, and flexible use of funds to support tenants in their housing.	▪ Annually, track the number of individuals served with rapid rehousing funds.
Strategy 2: In collaboration with DHHS and its housing and service stakeholders, support implementation of the goals, objectives, and strategies of the DHHS Strategic Housing Plan to eliminate barriers to housing and create quality affordable, accessible, and inclusive housing that supports the whole individual by improving services, funding, communication, and statewide coordination for the population we serve.	▪ Annually, participate on the DHHS Strategic Housing Plan and provide annual report to DAAS leadership on initiatives and progress of goal. ▪ By 2028, increase by 86% for the utilization of the targeting program.
Strategy 3: Provide training and technical assistance on homelessness to service providers at the state and community levels to establish an infrastructure that supports homeless service activities across systems of care.	▪ Annually, provide training and technical assistance on homelessness to service providers at the state and community level quarterly.
Strategy 4: Encourage participation in the targeting housing program among older adults and people with disabilities through partnerships with funded providers and local DSS offices to promote aging populations successfully moving into affordable housing.	▪ Annually, track increase in participation in the Targeting Program among older and disabled adults through partnerships with a minimum of five new HCCBG-funded providers and/or local DSSs to promote success of aging populations moving into affordable housing.
Strategy 5: Identify existing opportunities and other potential mechanisms to support learning for older adult community services providers about best practices, possible uses for HCCBG funding, and other considerations to help ensure safe and affordable housing for older adults.	▪ Annually, track number of HCCBG providers that are referral agencies.

Strategy 6: Identify what types of data are needed to measure progress in addressing homelessness, as well as methods by which to obtain this data. **Sub-strategy 6:** Collect, analyze, and report high-quality, timely data on homelessness to address inequities.	▪ Annually, report increase in affordable housing units (Using the Elder Housing Locator and the NC Housing Search, establish a baseline of affordable housing units available to older and disabled adults.

GOAL 3 EXPECTED OUTCOMES

- Increased availability and affordability of aging-in-place housing options and affordable housing options for older adults:
  - Increased availability and awareness of home modification at the state and local levels.
  - Increased access to resources and services that support access to safe and affordable housing.
- Reduced need for institutional care, such as nursing homes, and associated costs.
- Reduced housing insecurity and homelessness among older adults.
- Improved physical and mental health outcomes for older adults experiencing homelessness.
- Increased statewide coordination among housing, healthcare, and social service providers to better address the needs of homeless older adults and eliminate barriers to housing.
- Increased participation in the targeting housing program.
- Maintenance of housing stability.
- Implementation of DHHS Strategic Housing Plan.

Goal 4: Advance equity, accessibility, and inclusion through informal and formal caregiving support.

OBJECTIVE 4.1: Strengthen, support, expand, and diversify the direct care workforce to meet the growing care needs in NC.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Explore recruitment of older workers to provide direct care using Title V training funding to pay for Personal Care Aide or Certified Nursing Assistant (CNA) training.	▪ By December 2024, share a cross-state analysis report on the use of title V training funds to pay for PCA or CNA trainings.
Strategy 2: To enhance best practices, encourage home care agencies and educational institutions to partner with state agencies to support a ready and well-qualified direct care workforce.	▪ By June 2025, complete an analysis on rates and share with AAA and home and community-based providers.
Strategy 3: In collaboration with DMH, provide support to providers on trauma-informed care.	▪ Annually, track the number of webinars to caregivers on trauma-informed care and the number of providers who have received support on trauma-informed care.
Strategy 4: Expand opportunities for community involvement and volunteerism to increase the availability of services to older adults, people with disabilities, and family caregivers.	▪ Annually, encourage at least one AAA to host AmeriCorps program and disseminate information on AmeriCorps funding opportunities and training sessions in the community through Aging Network.

OBJECTIVE 4.2: Leverage resources and flexibility to provide Family Caregiver Support Program (FCSP) services across all five service categories – information, access, training/support, respite, and supplemental services – in all 100 counties.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: During the ARPA project period, continue using these funds to offer respite care services and broaden supplemental service offerings.	▪ Quarterly, analyze AAA ARPA funding spreadsheet every year. ▪ Annually, track the number of respite care services provided and supplemental services offered (As of 2023, there are 7 respite categories and 10 supplemental categories offered).
Strategy 2: DAAS FCSP will engage with the NC Caregiving Collaborative to prioritize the recommendations of the Raise Family Caregiver Report and develop an implementation strategy for advancing policy solutions for caregiving across the life span.	▪ By 2026, develop implementation plan for integrating strategies from the Raise Family Caregiver Report; In 2023, one area of focus was training around trauma-informed approaches to FCSP specialists.
Strategy 3: Help direct caregivers to the most appropriate services through the aging network including supporting older relatives as caregivers.	▪ Annually in November, recognize Governor's Proclamation of Family Caregiver Month. ▪ Annually, track the number of family caregivers and units served in ARMS (In Fiscal year 2022, 1021 caregivers received respite/48,708 units & 1222 caregivers received supplemental services/22,923 units). ▪ Annually, track the number of direct caregivers referred to appropriate services through the aging network.
Strategy 4: In collaboration with the AAAs, conduct program evaluation to identify strengths, challenges, and opportunities for improvement.	▪ Annually, track the number of family caregivers and units served in Aging Resources Management Systems (ARMS). ▪ By June 2025, conduct program evaluation to identify opportunities for improvement and provide recommendations by January 2026.
Strategy 5: Support the promotion and use of NC Caregiver Portal (Trualta), with an expanded emphasis on social isolation for caregivers.	▪ Quarterly, track the number of caregivers registered on Trualta every year with the goal of increasing the number of new caregivers each year by at least 900 caregivers (As of May 2023 there were 1,250 registered caregivers on the NC Caregiver Portal (Trualta)).
Strategy 6: In collaboration with DPH, provide an analysis on the health status of NC family caregivers using the Caregiver module included in the BRFSS survey.	▪ Annually, provide analysis to NC Caregiving Collaborative on the health status of NC family caregivers collected through BRFSS survey.

OBJECTIVE 4.3: Support the expansion of Project CARE (Caregiver Alternatives to Running Empty) services to unpaid caregivers of people living with Alzheimer's disease or other related dementias and explore additional grant opportunities to continue Lifespan Respite.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: DAAS' NC Lifespan Respite State Advisory Team will apply for ACL grant funds to sustain Lifespan Respite Voucher Program in 2023 to continue dissemination and expansion of respite services across the lifespan (funding will total $1.6 million).	▪ If funded, by September 2023, begin implementation and track the number of public and private partnerships established and expansion of direct provision of respite vouchers.
Strategy 2: Maintain an inventory of publicly funded respite options in NC.	▪ Every other year (2024 and 2026), update directory of Publicly Funded Respite Resources (As of 2023, there were 17 publicly funded respite options).
Strategy 3: Evaluate the capacity of individuals to use consumer direction for respite services.	▪ Annually, conduct a minimum of two trainings on consumer-directed options. ▪ Annually, assess utilization rates of vouchers used by caregivers via a survey of Lifespan Respite Voucher recipients.
Strategy 4: Seek funding to increase state allocation for Project CARE services to strengthen infrastructure and expand coverage across NC.	▪ Annually, provide presentations to advocacy groups on the impact of Project CARE and update infographic on respite utilization among Project CARE participants. ▪ By June 2027, track additional funding secured to increase state allocation for project CARE.
Strategy 5: Participate in the NC Caregiver Collaborative to analyze state data, legislative solutions, financing options, and promote best practices and strategies for supporting caregivers in NC.	▪ By June 2026, share identified legislative solutions and financing options with the aging network; annually thereafter, communicate best practices and strategies.

OBJECTIVE 4.4: Raise awareness of the impacts and challenges of Alzheimer's disease and related dementias for North Carolinians.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: DAAS will continue to work on BOLD NC initiatives focusing on risk reduction, advancing early detection, and supporting caregivers.	▪ By June 2024, implement recommendations on brain health and track the number of BOLD NC initiatives implemented (3 risk reduction initiatives, 4 advancing early detection initiatives, and 3 supporting caregiving initiatives); complete BOLD NC final report by June 2024.
Strategy 2: Provide leadership to a dementia-friendly communities workgroup for community leaders interested in beginning or growing a dementia-friendly community.	▪ Annually, track the number of community leaders involved in the dementia-friendly communities' workgroup and number of dementia-friendly communities created or expanded (In Fiscal Year 2022, there were 120 members on the Dementia Friendly Communities and Hospitals Network; As of March 2023, there are 6 Dementia Friendly Communities in NC according to USAging.).
Strategy 3: Train Dementia Friends Champions across the state to adopt appropriate language around dementia.	▪ Annually, track the number of Dementia Friends Champions trained (In Fiscal year 2022, there were 58 Champions trained).

Strategy 4: In partnership with the NC Dementia-Capable Coalition, work to accomplish recommendations of the NC Dementia Capable State Plan.	• Annually, provide report on progress made toward accomplishing the 33 recommendations of the NC Dementia Capable State Plan (work with the Dementia Capable Coalition to advance work on two of the 33 recommendations: 2.3 and 5.2).
Strategy 5: In partnership with the College of Health and Human Services at NC A&T, Center for Integrative Health Disparities and Health Equity, explore the shared risk and protective factors between brain health and other preventable risk factors/health behaviors, such as intellectual or developmental disabilities (IDD).	• Annually, establish at least one new partnership. • Annually, track the number of shared risk and protective factors identified between brain health and other preventable risk factors/health behaviors. • Annually, track the number of health disparities identified among racial/ethnic populations and IDD populations.

OBJECTIVE 4.5: Strengthen the "No Wrong Door" (NWD) access to aging and disability services and promote the development of a state system of long-term care that is coordinated.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Support the NC Center for Health and Wellness (NCCHW) in the creation of a No Wrong System through a 2-year implementation plan and governance structure.	• By 2024, collaborate with various agencies and organizations involved in the governance structure to develop 2-year implementation plan for developing NWD system. • By June 2027, develop NWD system.
Strategy 2: Support the intersection of the NWD Governance Structure with the Multisector Plan on Aging through support from the Center for Health Care Strategies (CHCS) and ACL.	• By December 2023, track the number of successful partnerships formed between NWD and MPA.
Strategy 3: Support person-centered planning for older adults and their caregivers across the spectrum of LTSS, including home, community, and institutional settings.	• Annually, track the number of older adults and caregivers participating in consumer-directed/person-centered planning. • Annually, conduct a minimum of two trainings on consumer-directed options to providers.
Strategy 4: Increase education and awareness through NC CARE360/NC 211 about how caregivers access long-term services and supports.	• Annually, track the number of older adults, caregivers, and service providers accessing NC CARE360/NC 211 for information and assistance.

OBJECTIVE 4.6: Ensure that people who need additional care can stay in their community and in the living arrangement of their choice.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Recommend in-home service employers implement a regular program of ongoing training and education for staff providing in-home services of at least 12 hours, with a focus on diversity, equity, and inclusion, disability sensitivity, and communication equity.	• Annually, track the number of in-home service providers participating in training and education and the number of employers implementing a regular program of ongoing training and education.
Strategy 2: In collaboration with the AAAs, DAAS will offer training to promote the expansion of participant directed/person-centered models of providing care.	• Annually, increase the Home Care Independence programs by two each fiscal year encompassed in this plan (In State Fiscal Year 2022, there were 6 HCI programs).

Strategy 3: Educate local in-home aide service providers about the use of American Rescue Plan Act of 2021 (ARPA) funding and strategize ways to forecast funding to address waitlists and shortages of staffing.	▪ By January 2024, document the number of local providers educated about ARPA funding. ▪ By September 2024, document the number of successful applications made for ARPA funding to address waitlists and shortages of staffing.

OBJECTIVE 4.7: Promote social, physical and emotional well-being through Adult Day Services and Program of All-Inclusive Care for the Elderly (PACE) program.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Support DHB in expanding PACE service areas across the state and increase capacity of existing programs by disseminating informational resources.	▪ Annually, track the number of new PACE programs/service areas established and evaluate the number of older adults 55+ served through PACE expansion efforts (In State Fiscal Year 2022, there are 11 PACE organizations operating in 12 locations in NC). ▪ Annually, support DHBs effort in expanding the number of PACE programs by four annually to areas that are not served by PACE.
Strategy 2: Conduct an evaluation of adult day care and day health programs, funding sources, and accessibility and transportation barriers.	▪ By June 2024, identify gaps in adult day care/day health programs and evaluate funding sources to support expansion efforts in rural areas. ▪ By June 2025, conduct evaluation in partnership with the AAAs to assess transportation barriers in accessing Adult Day Services and provide recommendations.
Strategy 3: Support expansion efforts in rural areas and equitable access for lower income populations.	▪ By December 2024, encourage the expansion of existing PACE programs to rural counties using evaluation conducted in June 2024.

GOAL 4 EXPECTED OUTCOMES	
OBJECTIVE 1	▪ Increased availability of skilled and qualified direct care workers to meet the growing demand for care. ▪ Improved quality of care for older adults and people with disabilities. ▪ Increased job satisfaction and retention among direct care workers. ▪ Increased diversity and cultural competency among direct care workers. ▪ Reduced burden on family caregivers and other informal caregivers. ▪ Increased understanding of caregiver needs and preferences. ▪ Expansion of existing HCBS direct care workforce.
OBJECTIVE 2	▪ Increased number of caregivers and number of counties supported in the FCSP. ▪ Improved awareness of and access to information and resources for family caregivers. ▪ Increased knowledge and skills among family caregivers through training and support programs. ▪ Increased availability and affordability of respite care options for family caregivers. ▪ Improved financial and material support for family caregivers through supplemental services. ▪ Reduced caregiver burden and improved quality of life for caregivers and care recipients. ▪ Improved caregiver health and wellness through analysis of health status of NC family caregivers.

OBJECTIVE 3	• Improved access to respite care for unpaid caregivers of people living with Alzheimer's disease or other related dementias. • Increased knowledge and skills among caregivers through training and support programs. • Expansion of direct provision of respite vouchers • Reduced caregiver burden and improved quality of life for caregivers and care recipients. • Improved health outcomes for caregivers and care recipients. • Increased awareness and support for respite care programs among policymakers and stakeholders.
OBJECTIVE 4	• Increased public awareness and understanding of the impacts and challenges of Alzheimer's disease and related dementias. • Improved access to information and resources for people living with Alzheimer's disease or other related dementias and their caregivers. • Increased support for research for Alzheimer's disease and related dementias. • Increased advocacy for policies and programs that support people living with Alzheimer's disease or other related dementias and their caregivers.
OBJECTIVE 5	• Improved access to services and supports for older adults and people with disabilities. • Improved coordination and integration of services across different programs and agencies. • Reduced confusion and frustration among consumers navigating aging and disability services. • Improved quality of care and outcomes for older adults and people with disabilities. • Improved efficiency and cost-effectiveness of the NWD system.
OBJECTIVE 6	• Increased availability of home and community-based services for older adults and people with disabilities. • Reduced reliance on institutional care, such as nursing homes. • Improved quality of life and independence for older adults, people with disabilities, and persons with hearing loss. • Reduced healthcare costs associated with institutional care. • Increased inclusion and recognition of caregivers in the person-centered planning process. • Expansion of participant directed/person-centered models of providing care for older adults and their caregivers.
OBJECTIVE 7	• Improved social, physical, and emotional well-being for older adults and people with disabilities. • Enhanced quality of life for participants and their families through a safe and supportive environment. • Increased availability and affordability of adult day services and PACE programs. • Improved access to healthcare and supportive services for older adults and people with disabilities.

GOAL 5: Incorporate innovative practices learned through COVID and create reliable systems and infrastructures that will have the capacity to serve the growing aging population, all while recognizing the need for communication equity to foster involvement from all stakeholders.

OBJECTIVE 5.1: Evaluate current systems and infrastructures in response to the evolving needs, services, and communication access for our aging population's well-being.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: In partnership with the AAAs, local service providers, advocates, and other key stakeholders, develop ARPA Sustainability plan through in-depth ARPA program evaluation and advocacy efforts. **Sub-strategy 1:** Conduct fiscal and programmatic monitoring to ensure that all COVID-19 related funds are expended as stipulated by ACL through in-depth ARPA services program evaluation to identify strengths, challenges, and opportunities for improvement. **Sub-strategy 2:** Examine initiatives undertaken with ARPA funds to determine innovations that should be continued with necessary state support.	▪ By June 2024, develop ARPA sustainability plan and complete in-depth program evaluation to determine innovations that should be continued with necessary support.
Strategy 2: Promote the expansion of home and community-based services to support older adults aging in the least-restrictive setting through increasing services.	▪ Annually, review DAAS wait list policy and include wait list maintenance in the overall HCCBG monitoring process. ▪ By June 2027, update the Home and Community Care Block Grant Manual and ensure that HCCBG providers are included in the update process.
Strategy 3: Support the business capacity and acumen of the AAAs through various methods, such as supporting the development of a Community Care Hub.	▪ Annually, track the number of training and technical assistance offered to AAAs to enhance their business capacity and acumen. ▪ By June 2026, develop Community Care Hub.
Strategy 4: In collaboration with the AAAs, implement local pilots to allow for innovation, creativity, and flexibility which recognizes, values, and incorporates into planning the regional and community diversity.	▪ Throughout the entire plan cycle, implement 1-2 local pilots annually to test innovative approaches that recognize, value, and incorporate regional and community diversity into planning for home and community-based services; evaluate the effectiveness of these pilots and use the findings to guide future planning and service delivery.

OBJECTIVE 5.2: Implement operational improvements and managerial efficiencies for critical services and supports.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Educate other divisions regarding programs available through DAAS and how the division may assist through partnering.	▪ Annually, track the number of divisions educated about DAAS programs and services and the number of distributed informational booklet about statewide aging and adult services and supports to other divisions through tracking log. ▪ Annually, by December of every year, obtain feedback from partnering divisions on the effectiveness of the education and partnership.

Strategy 2: Improve performance-based outcomes for services by adopting an active contracts management framework to educate vendors and providers.	▪ Annually, the contract manager will hold one meeting with contract administrators to establish monitoring, deadlines and expectation guidelines and track the percentage increase in the number of vendors and providers educated on performance-based outcomes. ▪ By June 2025, obtain feedback from vendors and providers on the effectiveness of the contracts management framework through survey. ▪ Through the life of the plan, 95% of all contracts will meet required deadlines.
Strategy 3: Expand and improve performance measures for DAAS programs and services in NCDHHS Open Window (DHHS Open Window captures information on services, programs, contracts, key planning and performance information).	▪ Annually and through life of the plan, review, revise and update program performance measures; Update DAAS program performance measures where available. ▪ Annually, track the number of new performance measures developed and implemented.
Strategy 4: Update DAAS policies, procedures, and manuals, setting measurable goals in services and contracts to assure best practice standards in compliance with the 2020 OAA Reauthorization.	▪ By December 2024, review all internal policies, procedures, and manuals to align with 2020 OAA Reauthorization. ▪ Annually, track the number of DAAS staff participation in state-level literacy training to establish communication guiding principles with the Office of Communication. ▪ Annually, track the number of policies, procedures, and manuals updated and feedback from stakeholders on the effectiveness of the updates.
Strategy 5: Convene a workgroup AAAs, providers, and DAAS staff to effectively monitor a waiting list policy for services provided by the Home and Community Care Block Grant.	▪ Annually, track percentage decrease in the waiting list time for services (ensure system captures accurate waiting lists). ▪ By June 2027, ensure inclusion of a review of wait list policy in monitoring process.
Strategy 6: Implement DHHS DAAS Modernization Roadmap Plan that integrates DAAS data, processes, and applications in phases, which includes the replacement of ARMS.	▪ By June 2027, in 4 phases, implement DAAS Modernization Roadmap Plan: develop and attain project costs and benefit at the beginning of each project phase. ▪ By June 2027, replace Aging Resource Management System (ARMS). ▪ Annually, track reduction in time and resources needed for data management and processing.
Strategy 7: Support data modernization efforts by using asset framing approaches and ensuring that data collection, analysis, interpretation, and dissemination are equity centered.	▪ By June 2024, establish a data that will be updated annually. ▪ By January 2024, communicate data back to the general public about the 2022-2023 listening session and community survey.
Strategy 8: Make infrastructure improvements by evaluating and modifying the internal structure of DAAS to ensure effective and efficient management and delivery of services.	▪ Annually, track the number of infrastructure improvements made through annual evaluation of internal structure of DAAS with leadership team; evaluate percentage increase in the efficiency of service delivery.
Strategy 9: Revise or replace the DAAS 101 Client Registration to ascertain client needs more effectively.	▪ By June 2025, conduct evaluation of DAAS 101 Client registration form for revisions. ▪ Annually thereafter, track the number of clients served based on the revised or replaced registration process.

OBJECTIVE 5.3: Expand efforts to assist older adults, people with disabilities, and their caregivers with emergency management and disaster preparedness planning, response, and recovery with communication equity.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Promote effective collaboration and coordination with North Carolina Emergency Management (NCEM) and leverage their successful partnership in the work of the State Emergency Response Team (SERT).	▪ Annually, participate in NCEM monthly meeting and track the number of successful collaborative efforts with NCEM and SERT in emergency preparedness and response efforts. ▪ Annually, participate in 100% of the state-sponsored Emergency Operations Centers drills/exercises.
Strategy 2: Collaborate with the AAAs and local emergency response agencies to provide additional support and encourage the expansion of the "call-down" logs systems and other appropriate communication processes to contact those with the highest social and economic needs prior to and following a hurricane and other natural events.	▪ Annually, track the number of meetings held with AAAs to help prepare for establishing a call-down system. ▪ Annually, track the number of individuals contacted through the "call-down" logs and other appropriate communication processes before and after a hurricane and other natural events.
Strategy 3: Strengthen emergency preparedness and response for older adults and people with disabilities to improve responsiveness through collaboration with the Emergency Operations Center (EOC) CMIST Advisory Committee.	▪ Annually, participate in monthly CMIST Advisory Committee meetings and report back to DAAS leadership. ▪ By June 2026, develop and disseminate emergency preparedness and response plans and/or public information specifically for older adults and people with disabilities based on committee involvement.
Strategy 4: DAAS will serve on the NC Emergency Management Registry Workgroup to explore and/or develop tools, processes, best practices, trainings, and toolkits for county and municipalities desiring to assist their residents with access and functional needs during a disaster.	▪ Annually, serve on Workgroup and report back to DAAS leadership on progress towards the development of tools, processes, best practices, trainings, and toolkits for counties and municipalities to assist residents with access and functional needs during a disaster.
Strategy 5: Assess lessons learned from the COVID-19 pandemic to strategize, develop, and update communication plans, policies, and procedures and continue supporting ongoing COVID-19 response and recovery needs, such as vaccine information and assistance.	▪ By December 2024, assess lessons learned from the pandemic to update communication plans. ▪ By June 2025, develop and implement updated communication plans, policies, and procedures based on lessons learned from the COVID-19 pandemic.
Strategy 6: DAAS will support recovery efforts by coordinating with the disaster team and key players to provide annual trainings and assigning and deploying appropriate personnel to assist county departments of social services, area agencies on aging and other local entities as requested.	▪ Annually, provide emergency and disaster training to DAAS staff and assign appropriate personnel for deployment. ▪ Annually, track successful coordination and deployment of personnel to assist in recovery efforts for county departments of social services, Area Agencies on Aging, and other local entities.
Strategy 7: DAAS will encourage local providers and the AAAs to embed DEI trainings into emergency planning.	▪ By June 2025, integrate DEI trainings into emergency planning for local providers and the AAAs. ▪ Annually thereafter, track the number of distributed materials (flyers, brochures, etc.) on a variety of emergency topics, including DEI trainings, to the 16 AAAs for dissemination to the target populations.
Strategy 8: Collaborate and consult with the DSDHH emergency preparedness regional staff to ensure that communication access is provided before, during, and after events.	▪ By June 2024, establish relationship with DSDHH emergency preparedness coordination and DSDHH regional staff to ensure that communication access is provided before, during, and after events for individuals who are Deaf, Hard of Hearing, or DeafBlind.

OBJECTIVE 5.4: Develop a cross-sector, state-led multi-sector plan to transform the infrastructure and coordination of services for our rapidly aging population.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: In partnership with DHB, mine data across departments and examine existing research to identify current and future trends in the aging and disability population.	▪ By July 2023, develop a contractual agreement with UNC-Chapel Hill to develop and conduct the NCI-AD survey by January 2024. ▪ By January 2024, track the number of departments data was mined from, number of research sources reviewed, usefulness of identified trends for informing policy or program decisions (measured through surveys or interviews with stakeholders). ▪ By June 2024, establish a data dashboard for the Multisector Plan for Aging that will be updated annually. ▪ By December 2024, develop reports gathered from information received that allows North Carolina to compare data with other states, and communities within the state.
Strategy 2: Map past and current initiatives in NC including state, regional, and local efforts to create a tapestry and coordinated infrastructure around all various aging initiatives occurring in North Carolina.	▪ By December 2023, update past and current planning initiatives to help identify any gaps in current infrastructure and annually thereafter, continue updating initiatives.
Strategy 3: Form governance structure for MPA Stakeholder Advisory Committee (SAC) to drive the collaborative effort to develop the 10-year plan.	▪ By June 2023, host half-day kickoff meeting with subject matter experts across the state and track tangible outcomes from the meeting, such as identified action items and next steps. ▪ By August 2023, establish Stakeholder Advisory Committee and subcommittees. ▪ By May 2024, develop first two years of the 10-year Multisector Plan for Aging.
Strategy 4: Age my Way NC partners will promote age-friendly efforts and study ways to promote public understanding of older adults' challenges and evaluate the need for new state programs to address challenges.	▪ Annually, Age My Way NC partners will continue educating public about survey findings and evaluate the need for new programs to address current needs. ▪ Annually, collaborate with AARP NC on age-friendly statewide initiatives as a part of the Age-Friendly network.

OBJECTIVE 5.5: Support the implementation of the Medicare-Medicaid integration strategy to better meet the diverse needs of the aging population.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Older adults and the community aging and disability providers who serve them will be educated on the availability of services that foster independence, self-sufficiency, enhance planning, and communication access.	▪ Annually, track number of older adults who receive information on available services and provide community aging and disability providers training on available services.
Strategy 2: Educate older adults about the Medicare-Medicaid dual-eligibility, structure, and phase in of populations and services.	▪ Annually, in collaboration with DHB, host 2 webinars on Medicare-Medicaid dual-eligibility.

Strategy 3: Collaborate with other DHHS divisions to increase Medicaid administrative claiming and provide eligible individuals access to Medicaid treatment.	• Annually, track the number of eligible individuals who receive access to Medicaid.
Strategy 4: Develop workflows to ensure continuity of care and seamless experiences for individuals as they transition to MLTSS program.	• Annually, track the percentage of individuals who transition to the MLTSS program without interruption of services and the number of individuals who receive services from the MLTSS program.

GOAL 5 EXPECTED OUTCOMES	
OBJECTIVE 1	• Improved sustainability planning and program evaluation for aging services and supports to better identify strengths, challenges, and opportunities for improvement. — Development of sustainable policies and decisions that affect older adults and maximizes community benefits. • Enhanced capacity to evaluate innovative programming to meet the evolving needs of the aging population. • Expanded, standardized, coordinated, and communication accessible home and community-based services that support the well-being of older adults. • Increased business capacity and acumen of AAA to better serve aging populations. — Increased number of aging providers/staff trained in strategic business planning.
OBJECTIVE 2	• Enhanced management and oversight of contracts to improve service delivery. • Updated policies, procedures, and manuals to improve the quality of critical services and supports. • More effective monitoring of waiting list policies to ensure prompt access to services and supports. • Expansion of reliable data on aging population, services provided, and expenditures. • Increased transparency and quality of service delivery. • Increased management and allocation of resources. • Improved quality and equity in service delivery.
OBJECTIVE 3	• Increased aging network knowledge of available resources for preparedness planning. — Improved emergency management and disaster preparedness planning, response, and recovery for older adults, people with disabilities, those with hearing loss and their caregivers. — Increased older adult awareness and understanding of available resources during states of emergency. • Enhanced communication acccess to ensure that all aging populations receive critical information during emergencies. • Increased staff participation in state-sponsored Emergency Operations Center drills/exercises.
OBJECTIVE 4	• Statewide mechanism to support aging and innovation across the lifespan are identified. • Improved coordination and integration of services to ensure comprehensive support for aging populations. • Enhanced sustainability of aging-related services to meet the growing needs of aging populations. • Effective systems of change model. • Improved involvement of cross-sector agencies in aging issues.
OBJECTIVE 5	• Increased access to health care services for older adults with diverse needs. • Improved health outcomes for older adults through more coordinated care. • Enhanced sustainability of health care services for aging populations. • Increased access to communication access for aging populations with hearing loss.

GOAL 6: Advance equity by supporting and encouraging older adults of all backgrounds and their support systems to access information that helps them make informed choices about support services at home or in the community.

OBJECTIVE 6.1: CONTINUE TO EXPAND EQUITY-CENTERED COMMUNICATIONS TO OLDER ADULTS, PEOPLE WITH DISABILITIES, AND FAMILIES OF ALL BACKGROUNDS.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Partner with the AAAs and other community organizations to design and implement outreach and training plan with communication access to support OAA funded programs throughout NC.	▪ Annually, track the number of community organizations partnered with and the number of materials created and disseminated on OAA funded programs.
Strategy 2: In coordination with the AAAs, review, evaluate, and revise all internal policies, procedures, and outreach materials to focus on using person-centered language and promote equity and inclusion.	▪ By June 2024, DAAS leadership team will offer reframing aging workshop to DAAS staff. ▪ By June 2026, review, evaluate, and revise internal policies, procedures, and outreach materials and review HCCBG service standards for language that do not promote equity and inclusion of marginalized populations. ▪ By June 2027, track the number of policies, procedures, and outreach materials reviewed, evaluated, and revised based on level of adherence to anti-ageism language/imagery and person-centered language and obtain feedback from partners/stakeholders on the impact of language changes on promoting equity and inclusion.
Strategy 3: Research marketing and outreach programs, as well as best practices, to increase participant diversity in evidence-based health promotion and disease prevention programs.	▪ By June 2025, as a part of program evaluation, provide analysis of marketing and outreach programs to increase participant diversity.
Strategy 4: In collaboration with the Office of Equity, strategize ways to incorporate inclusivity in our programs and events, through racial diversity in marketing materials, ability/disability, diversity in sexual orientations, diversity in gender identities, veteran engagement, and increased communication access and language resources.	▪ Annually, track the number of meetings held to discuss strategies for incorporating inclusivity in programs and events and the number of initiatives implemented to increase inclusivity in programs and events. ▪ By June 2024, create a guiding principles checklist that ensures all DAAS marketing materials and events take into consideration the diversity of racial, ability/disability, sexual orientation, and gender identifications.
Strategy 5: Work with the DSDHH, Division of Services for the Blind (DSB), the NC Department of Military and Veteran Affairs, and the DVRS to devise a plan to allow access to provide regular training to aging service providers.	▪ Arrange a one-hour presentation by the Division of Services for the Deaf and Hard of Hearing (DSDHH) and Division of Services for the Blind (DSB) at the Ann Johnson Institute once every 3-year cycle of training.
Strategy 6: Through partnerships with universities and organizations, explore ways to collect inclusive data about sexual orientation and gender identity (SOGI) in program evaluations.	▪ By June 2025, train staff on the importance of collecting SOGI data. ▪ By June 2026, all program evaluations will incorporate SOGI data.

Strategy 7: Address stigma attached to aging and needing services by using a Personal Determinants of Health (PDOH) approach and increasing opportunities for multigenerational community activities and partnerships with local organizations, such as school systems.	▪ Annually, track number of multigenerational community activities and partnerships with local organizations developed across the state that address stigma (measured through surveys asking for feedback from participants on the impact of multigenerational activities on addressing stigma). ▪ By 2027, partner with school systems to promote multigenerational community activities and partnerships.
Strategy 8: Educate aging network to begin by using inclusive terms, phrases, and language that do not presume a sexual orientation, gender identity, or relationship status and also explore LGBTQ-specific programming to create a welcoming and inclusive environment for all older adults.	▪ Annually, host 3 educational webinars with SAGE and Carolina Aging focused on promoting SAGE resources and guides on inclusiveness to the aging network. ▪ Annually, provide aging network staff training on using inclusive terms, phrases, and language and obtain feedback on the impact of inclusive language on creating a welcoming and inclusive environment for all older adults.
Strategy 9: In partnership with the Office of the Governor, the NC Coalition on Aging (NCCOA), and advocacy organizations, such as AARP NC and SAGE USA, work to educate policymakers and promote an "Aging in All Policies."	▪ Annually, provide education to DHHS and cabinet leads on Aging in All Policies. ▪ Annually, provide technical assistance to support collaboration among local aging providers, home builders, county planning departments and others to promote aging in all policies.
Strategy 10: In Collaboration with the Office of Equity, increase the knowledge and skills of staff about diversity, equity, and inclusion through DAAS DEI council and Department DEI council work.	▪ Annually, track the number of speakers presenting at monthly DEI lunch and learn series and the number of trainings on topics such as cultural competency and biases. ▪ By December 2023, develop survey to receive feedback from staff on the impact of DEI training/lunch and learns on promoting equity and inclusion.

OBJECTIVE 6.2: FOSTER EQUITY AND INCLUSION ACROSS MULTIPLE STRUCTURALLY EXCLUDED AND INADEQUATELY REPRESENTED POPULATIONS OF GREATEST SOCIAL AND ECONOMIC NEED AND THEIR COMMUNITY NETWORKS.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Implement local and national best practice initiatives and equitable communication in all aspects of daily living to empower residents to exercise autonomy over their lives in long-term care settings.	▪ Annually, track the number of best practice initiatives implemented in long-term care settings. ▪ Quarterly, track the level of resident autonomy reported by residents and staff and impact of equitable communication practices on promoting resident autonomy through querying new residents and their families regarding the Bill of Rights being in their admissions packet or being informed of their rights.
Strategy 2: In collaboration with the AAAs, make long-term investments in native community-based infrastructure with grants, contract services, technical assistance, and other targeted resources to support the social and healthcare needs of older adults and their family caregivers.	▪ Annually, track the number of grants and resources explored to support native community-based infrastructures. ▪ By June 2027, evaluate the number of successful native community-based infrastructure investments made.

Strategy 3: Collaborate and provide technical assistance to Native Americans and advocates in their communities to promote access to available services.	▪ Annually, provide a minimum of two technical assistance training sessions to Eastern Band of Cherokee Indians (ECBI) and Lumbee Tribe staff. ▪ Annually, collaborate with the Area Agencies on Aging (AAAs) to compile a list of services that encourage participation among Native Americans. ▪ Annually, track the number of minority individuals served in ARMS and continue increasing the proportion of minority individually served.
Strategy 4: Encourage the aging network to engage in outreach and co-host programming with local LGBTQ+ organizations and HIV providers.	▪ Annually, host at least one program with local LGBTQ+ organizations and HIV providers and receive feedback from participants on the impact of the events on promoting equity and inclusion for LGBTQ+ and HIV positive older adults.
Strategy 5: In partnership with SAGE USA and local partners, prepare, publish and disseminate educational resources about available services and resources for people living with HIV through partnerships with HIV service providers and for LGBTQ+ older adults with LGBTQ+ organizations.	▪ By June 2024, develop educational resources that promote the awareness of available services and resources for people living with HIV and LGBTQ+ older adults.
Strategy 6: Implement culturally appropriate educational and coaching strategies to help historically marginalized family caregivers safely, competently, and confidently navigate the state's social services and healthcare systems.	▪ Annually, provide culturally appropriate materials on service and supports for historically marginalized caregivers.
Strategy 7: Collaborate with El Centro's Department of Civic and Community Participation to implement culturally appropriate educational training and resources and host events in collaboration with local senior centers.	▪ Annually, host meetings with El Centro to discuss strategies on promoting equity and inclusion for older adults in Hispanic/Latinx communities. ▪ Quarterly, host culturally appropriate educational training in collaboration with El Centro's Department of Civic and Civic and Community Participation.
Strategy 8: Identify organizations that have dedicated holocaust survivor programs and disseminate information to the aging network.	▪ Annually, update and distribute the list of organizations with dedicated holocaust survivor programs to the Area Agencies on Aging.
Strategy 9: Increase outreach through the AAA area plans to consumers with limited English proficiency.	▪ Annually, track the number of consumers with limited English proficiency reached through outreach efforts in AAA area plans and track the number of collaborations with other agencies/ institutions on minority issues to establish a baseline. ▪ By June 2025, create a committee and compile a list of services that encourage participation among those individuals with limited English proficiency.

Strategy 10: Through community inclusion and strengthened collaboration with public-private partnerships, such as businesses, training institutions, and the AAAs, increase awareness of and participation in the Senior Community Service Employment Program (SCSEP) to reach the capacity of the program.	▪ Annually, track percentage of SCSEP participants who exited into unsubsidized employment, percentage of SCSEP participants who retained unsubsidized employment for six months after exiting program, and total earnings of SCSEP participants in unsubsidized employment six months after exiting program (As of July 2022, 186 participants) ▪ Annually, track total number of hours (in the aggregate) of community service employment provided by SCSEP. ▪ Annually, track the number of community inclusion and public-private partnership collaborations established to increase awareness and participation in the SCSEP program. ▪ Annually, through survey, obtain feedback from participants on the impact of the program on promoting equity and inclusion for older adults.
Strategy 11: In collaboration with AAAs, ensure that professionals in rural areas have access to training and technical support.	▪ Annually, target rural areas to provide training and technical support to rural professionals. ▪ By June 2026, provide report that examines the need for assisting rural service areas.
Strategy 12: Collaborate with DSDHH to identify ways to increase involvement of the Deaf, Hard of Hearing, and DeafBlind community in DAAS initiatives and programs.	▪ Annually, track the number of Deaf, Hard of Hearing, and DeafBlind community members who participated in DAAS initiatives and programs. ▪ Arrange a one-hour presentation by the Division of Services for the Deaf and Hard of Hearing at the Ann Johnson Institute once every 3-year cycle of training.

OBJECTIVE 6.3: ADVANCE DIGITAL EQUITY AND CONNECTIVITY LITERACY BY SUPPORTING A COMPREHENSIVE PERSON-CENTERED, COMMUNITY-INVOLVED APPROACH.

STRATEGY	PERFORMANCE MEASURES
Strategy 1: Work with North Carolina Department of Information Technology's (DIT) Office of Digital Equity and Literacy to ensure that collaborative digital equity projects are inclusive of older adults and all promotional materials are provided with communication access.	▪ By June 2024, develop a checklist to ensure that all digital equity projects are inclusive of older adults and that communication access is provided in all promotional materials.
Strategy 2: Contract with the Center for Digital Equity to develop a unified systematic approach to address the needs for digital inclusion and literacy of older adults by creating a project toolkit, curriculum, and train-the-trainer materials across the state.	▪ By December 2023, develop a project plan with clear timelines and deliverables for the development of the project toolkit, curriculum, and train-the-trainer materials. ▪ By June 2024, develop the toolkit, curriculum, and train-the-trainer materials and annually thereafter, track the number of trainings held for community lay leaders and the number of outreach materials developed and disseminated to drive awareness of digital navigators and education strategies. ▪ By December 2025, create screening and referral pathways to connect people to resources, devices, and digital navigators.

	▪ Annually, monitor progress on the project plan and ensure that the deliverables are completed on time and within budget. ▪ By June 2027, evaluate the effectiveness of the project toolkit, curriculum, and train-the-trainer materials by conducting surveys and collecting feedback from trainers and participants.
Strategy 3: Explore opportunities for expanding partnerships with the North Carolina Assistive Technology Program and The Division of Services for the Deaf and Hard of Hearing to ensure older adults have safe and reliable support agencies that can consult with consumers, professionals and others to build their capacity to use or provide digital equity and connectivity that is physically and communication accessible.	▪ Annually, track the number of partnerships formed with the State Assistive Technology program and evaluate the potential benefits and risks of each opportunity. ▪ Annually, track the number of partnership agreements created that outlines the roles and responsibilities of each partner and the expected outcomes of the partnership.
Strategy 4: Align work with NCCHW's Social Bridging Project to ensure digital equity needs are addressed.	▪ Annually, track the number of meetings with the NCCHW Social Bridging Project leads to support and integrate work with the Digital Equity grant and identify areas of overlap. ▪ By June 2024, develop a plan for collaboration that leverages the strengths of both projects to address the digital equity needs of older adults. ▪ Annually thereafter, monitor progress on the plan and evaluate the effectiveness of the collaboration by collecting feedback.

GOAL 6 EXPECTED OUTCOMES	
OBJECTIVE 1	▪ Improved access to information and resources for aging populations. ▪ Enhanced knowledge and skills of staff in the aging network about issue around inequity. ▪ Increased inclusivity in aging programs and events. ▪ Increased awareness of available services and supports for aging populations. ▪ Improved health outcomes through increased understanding of health information.
OBJECTIVE 2	▪ Improved access to critical services and supports for underrepresented populations. ▪ Enhanced well-being and quality of life for all aging populations. ▪ Increased rate of participation among individuals with greatest social and economic need. ▪ Improved participant satisfaction with service delivery. ▪ Increased communication accessibility in all areas.
OBJECTIVE 3	▪ Increased digital and connectivity literacy among aging populations. ▪ Improved access to digital resources and technology for aging populations. ▪ Enhanced social connectivity and engagement among aging populations through technology. ▪ Increased collaboration and connections for opportunities for social connectivity.

E. NC STATE AGING PROFILE (EXCERPTS)

STATE PROFILE

NORTH CAROLINA AGING PROFILE 2021

Projected Population Change, 2021-2041

	2021		2041		% Change 2021-2041
Age	NC #	NC %	NC #	NC %	
Total	10,556,299		12,936,967		23%
0-17	2,257,066	21%	2,600,043	20%	15%
18-44	3,779,034	36%	4,457,480	35%	18%
45-59	2,046,769	19%	2,431,551	19%	19%
60+	2,473,430	23%	3,447,893	27%	39%
65+	1,817,132	17%	2,715,844	21%	50%
85+	197,946	2%	422,918	3%	114%

Race and Ethnicity, Age 65 and Older, 2021

Race/Ethnicity	NC %	US %
White	78%	80%
Black or African American	17%	9%
American Indian	1%	1%
Asian	2%	5%
Some Other Race	1%	3%
Two or More Races	1%	3%
Hispanic/Latino	2%	9%
White, Not-Hispanic or Latino	77%	76%

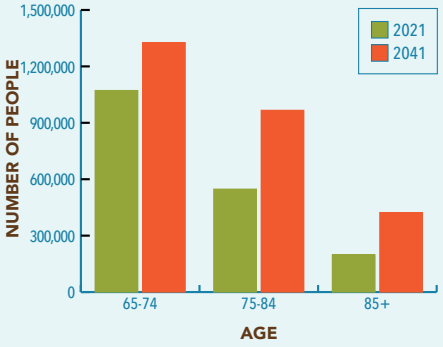
Social and Economic Characteristics of Population, Age 65 and Older, 2021

Characteristics	NC %	US %
100% Poverty	9%	10%
100-199% Poverty	20%	18%
Speak English Less than "Very Well"	2%	9%
Veterans	17%	16%
Living Alone	27%	26%
Less than High School	14%	14%
High School Graduate (Includes Equivalency)	30%	30%
With a Disability	34%	33%
Median Household Income of Householder 65 Years and Over	45,261	50,523
In Labor Force	18%	19%

STATE RANKINGS

TOTAL POPULATION	OVER 65+ YEARS OLD
#9 (10,556,299)	#9 (1,817,132)

Projected Growth, 2021-2041



In-migration & Kinship Care, 2021

45,841
Total people 60+ who moved from other states and abroad

37,826
Age 60+ Grandparents responsible for Grandchildren

Leading Causes of Death, Age 65 and Over

Rank	Cause of Death	# of Deaths	% of Total Deaths
1	Diseases of the heart	16,548	20%
2	Cancer – All Sites	14,731	18%
3	COVID-19	9,112	11%
4	Cerebrovascular Disease	4,846	6%
5	Alzheimer's Disease	4,197	5%

1

GLOSSARY

Disability – A long-lasting physical, mental, or emotional condition that makes it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering.

- ***Ambulatory –*** Serious difficulty walking or climbing stairs
- ***Independent living –*** Difficulty doing errands alone
- ***Hearing –*** Deaf or having serious difficulty hearing
- ***Cognitive –*** Difficulty remembering, concentrating or making decisions
- ***Self-care –*** Difficulty bathing or dressing
- ***Vision –*** Blind or serious difficulty seeing even with glasses

Household – A household includes all the people who occupy a housing unit as their usual place of residence. Household types are arranged into 2 groups. A ***family household*** contains at least 2 persons, the householder and at least 1 other person related to the household by birth, marriage or adoption. A ***nonfamily household*** may contain only one person, the householder or additional persons who are not relatives of the householder.

Householder – The person, or one of the people, in whose name the home is owned, being bought, or rented.

Income – "Total income" is the sum of the amounts reported separately for wages, salary, commissions, bonuses, or tips; self-employment income; interest, dividends, net rental income, royalty income, or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); any public assistance or welfare payments from the state or local welfare office; retirement, survivor, or disability pensions; and any other sources of income received regularly such as Veterans' (VA) payments, unemployment compensation, child support, or alimony.

Labor force – The labor force includes all people classified in the civilian labor force, plus members of the U.S. Armed Forces (people on active duty with the United States Army, Air Force, Navy, Marine Corps, or Coast Guard). The Civilian Labor Force consists of people classified as employed or unemployed.

Median income – The median income divides the income distribution into two equal groups, one having incomes above the median, and other having incomes below the median.

Poverty – The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If the total income for a family or unrelated individual falls below the relevant poverty threshold, then the family (and every individual in it) or unrelated individual is considered in poverty. The poverty threshold (2021) for a person 65 and older is $12,996 and for two people (householder aged 65 and older) is $16,400.

Race/Ethnicity – The Census Bureau collects racial data in accordance with guidelines provided by the US Office of Management and Budget. The data is based on self-identification in which residents choose the race or races with which they most closely identify. Hispanic or Latino refers to an ethnic category, a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.

Definitions of other terminology used in the report are available in the glossary of American Community Survey at: http://factfinder.census.gov/home/en/epss/glossary_a.html

F. DEMOGRAPHIC DATA

North Carolina is home to an estimated 11 million people of which 1.8 million are 65 and over – it ranks 9th nationally in the total population and population 65 and over [1]. The baby boomers, born 1946 – 1964, are once again front and center as they pass milestone dates in record numbers. North Carolina communities will experience a significant growth in the proportion of population 60 and over, as the wave of the 2.4 million baby boomers has begun entering the retirement age. In 2021, 1 in 6 people in North Carolina were aged 65 and over, and by 2031, there will be more people aged 65 and over than children under 18 in the state [2]. In the next two decades, of the people 65 and over, ages 75-84 will be the fastest growing segment and beyond 2030, the proportion of older adults 85 and over will increase as the baby boomer population moves into these age groups [2]. In addition, people are living longer than ever, and the state continues to attract more people from other states and abroad. This unprecedented growth of the oldest older population in the coming decades in aging creates a higher need for long-term services and supports.

Projected Population Change 2021-2041

	2021		2041		% Change 2021-2041
	#	%	#	%	
Total	10,556,299		12,936,967		23%
0-17	2,257,066	21%	2,600,043	20%	15%
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65+	1,817,132	17%	2,715,844	21%	50%
85+	197,946	2%	422,918	3%	114%

Source: NC Office of State Budget and Management, Population estimates and projections

Looking forward from the present to 2041, the proportion of population 65 and over will increase from 1.8 million to 2.7 million. [2] The necessity to plan for this changing age profile is already here as the demand for services continues to increase. From education to transportation to housing to community services, local and state planners and providers are having to take into account the needs of the older residents, as well as effective use of the many resources older adults bring to their communities.

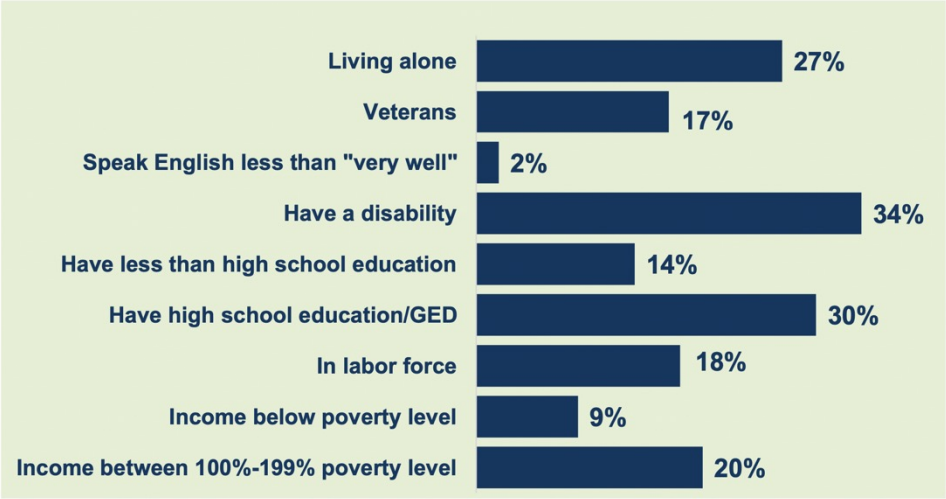
The Older American Act (OAA) specifies that its funds should be directed to "older individuals with greatest economic and social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas)" [Section 305 (a) (2) (E)]. Many older North Carolinians fall into one or more of these targeted groups, and such "double jeopardy" (and sometimes triple jeopardy or higher) make them particularly vulnerable. An estimated 2% of residents 65 and over speak English less than "very well" in the state. [3]

Racial and ethnic diversity is often linked both to economic security and to the likelihood of living with chronic illness or disability that creates a need for support services. Of all North Carolinians age 65 and over, 23% are members of ethnic minority groups, but unlike many other states, most are African-Americans (17%, compared to 9% nationally) [3]. A higher proportion of African-Americans lives in rural counties and are linked to lower median household income and level of education, higher rates of poverty, and disabilities. Around 5% of the minority population 65 and over belongs to other groups, including American Indians, Hispanic, and Asians [3]. The state has welcomed immigrants and refugees from Vietnam and Russia, to name just two groups, but they are concentrated in just a few counties. Although the state has seen an increase in the Hispanic/Latino population in the past decade, most are younger than 60, and 2% of adults 65 and over belong to that ethnic group. [3] The increasing diversity will create new challenges and opportunities in providing services that reflect the interests and culture specific needs of the population. North Carolina will continue to become more diverse as more people migrate into the state from other countries.

Of people age 65+ in North Carolina:

- 9% live below the poverty level compared to 10% nationally, and 20% live between 100% and 199% of poverty, compared to 18% nationally. [3] In 2021, the poverty threshold (US Census) for an individual was $12,996 and $16,400 for a couple with a householder 65 and older.
- 14% had less than high school education and another 30% had a high school diploma, GED, or alternative. [3]
- 27% live alone and are vulnerable to social isolation. [3]
- 34% of people age 65 and over, reported having at least one disability, and as may be expected, the proportion affected rises with age. [3]

Status of those 65 and Older (as a % of age group)

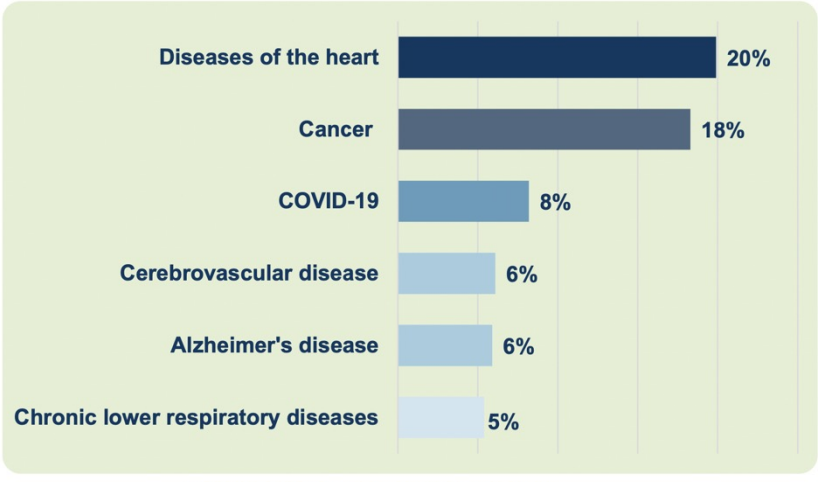


Older adults **living alone** at risk of **social isolation, loneliness** and **poor health outcomes**

Source: US Census, American Community Survey 2021 five-year Estimates

As elsewhere in the nation, heart disease is the leading cause of death among people ages 65+ in this state. [4] The fifth leading cause of death in the state is Alzheimer's disease. [4] Unlike some of the other causes of death, which have a relatively short course, dementia produces progressive disability, often over a decade or more, before ending the lives of those who have it. The number of older North Carolinians with Alzheimer's disease is projected to increase from 180,000 in 2020 to 210,000 in 2025. [5]

Leading causes of death among people age 65 and over, 2021



Physical activity, engagement, proper nutrition, clinical preventive services **promote health**

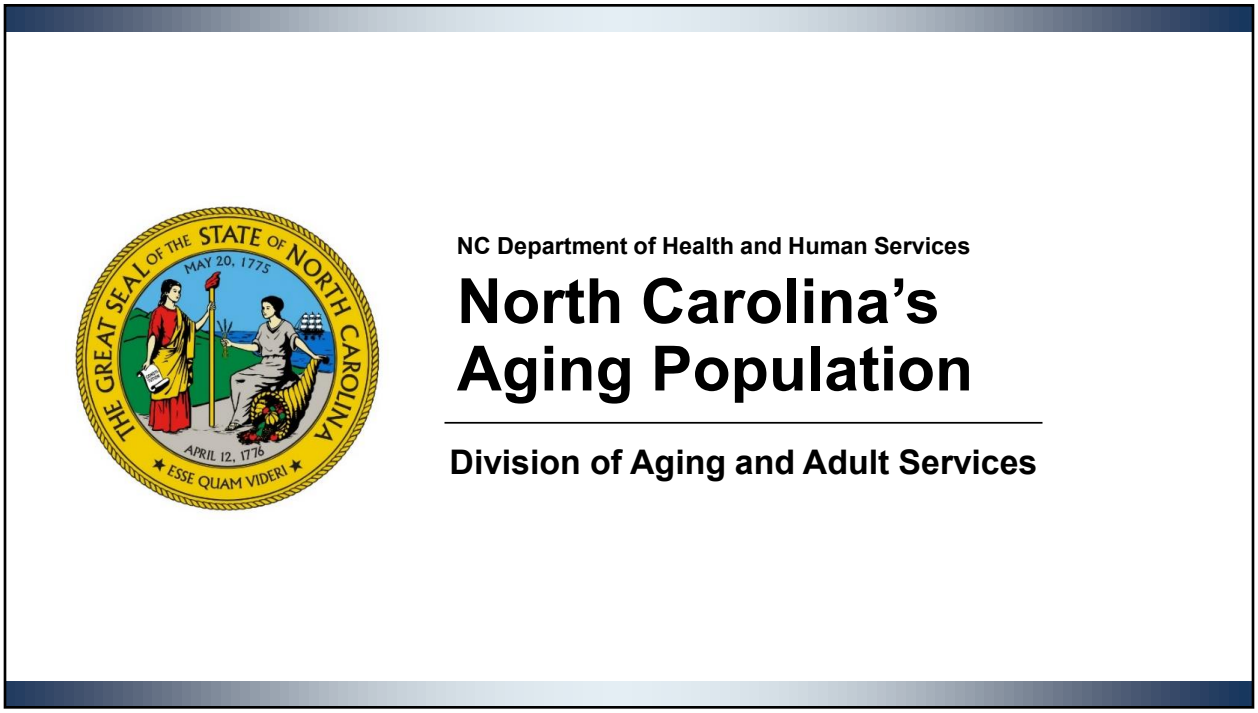
Source: NC State Center for Health Statistics

The NC Division of Aging and Adult Services is enjoined by the older Americans Act to "promote the development and implementation of a state system of long-term care that is a comprehensive, coordinated system that enables older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of the older individuals and their family caregivers" [Section 305 (a) (3)]. Established in 1992 under NCGS 143B-181.1(a)(11), the Home and Community Care Block Grant (HCCBG) was devised to provide a common funding stream for a comprehensive and coordinated system of 18 home and community-based services for older adults ages 60 and older with preference to those who are economically and socially needy. Services provided under HCCBG allow individuals to remain in their homes and communities rather than moving to a more costly residential or nursing setting. The typical client receiving at least one HCCBG service is an 83-year-old Caucasian woman who lives alone. HCCBG services are targeted to older adults (60+) who are low-income and/or minority. Priority is given to eligible older adults who (1) have a substantiated case with Adult Protective Services, (2) are at risk of abuse, neglect or exploitation, (3) are at-risk of placement or substitute care, or (4) have extensive activity of daily living (ADL) and instrumental activity of daily living (IADL) needs.

As public funding decreases it is of importance to recognize the system of care that rests with the families and friends of people with disabilities. To provide one example, in 2021, an estimated 356,000 North Carolinians provided paid care for family members with dementia, which would have cost over $7 billion to replace with paid care [5]. The cost savings owing to family caregivers also extends to other generations, with nearly 37,826 grandparents 60 and over in the state responsible for raising grandchildren under age 18 [6].

In summary, North Carolina has a large, economically and ethnically diverse older population. With this diversity come both special assets and challenges. We must be aware that those who face disabilities, disparities of income and health care, and the responsibilities of care for grandchildren are more likely to need public services and supports. While meeting the needs of today's older adults, our state is also witnessing the first steps of the next transition of baby boomers. With challenges come opportunities. The opportunities to use the skills of older adults for civic engagement and volunteerism; engage in innovation and redesigning services; maximizing the use of resources; and rising to the challenges through collaborate approaches to improve lives.

NC's Aging Population Powerpoint



Aging Population In North Carolina

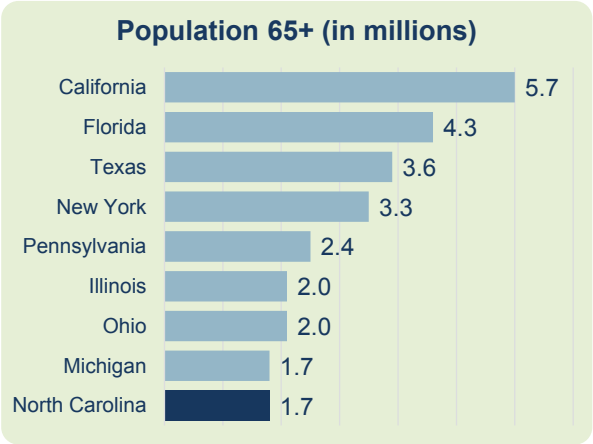
- Population Estimates and Projections
- Socio-Economic Characteristics
- Health and Well-Being

Estimates & Projections

North Carolina's National Rankings

9th in total population

9th in population 65+



Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table B01001: Sex by Age.

Projected NC's Population 2021-2041

	2021		2041		% Change 2021-2041
Age	#	%	#	%	
Total	10,556,299		12,936,967		23%
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85+	197,946	2%	422,918	3%	**114%**

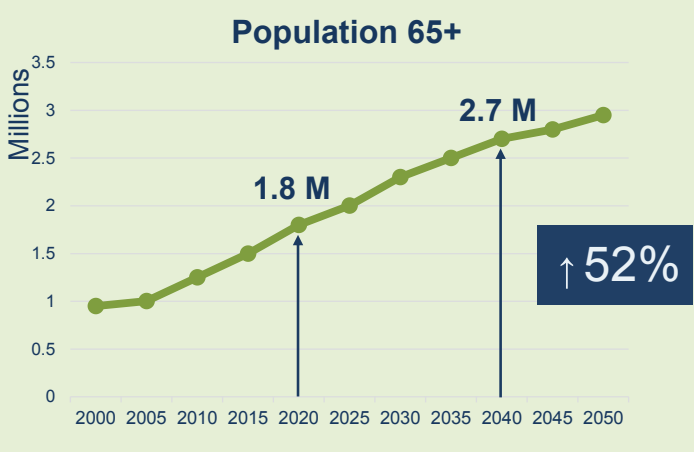
Source: NC Office of State Budget and Management, Standard Population Estimates, 2021; Population Projections, Vintage 2041, www.osbm.nc.gov/facts-figures/population-demographics

Growth of Aging Population

2021: **1** in **6** were 65+
2024: **1** in **5** will be 65+
By 2031
More 65+ than under 18

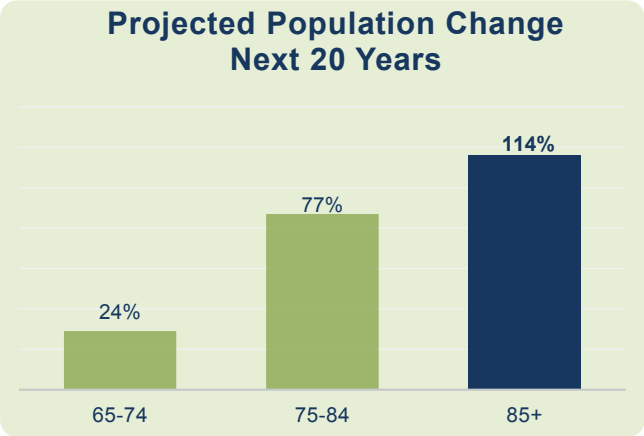
Causes

Aging baby boomers
Low fertility rates
Increased longevity
Migration



Source: NC Office of State Budget and Management, Standard Population Estimates, Vintage 2021; Population Projections, Vintage 2041, www.osbm.nc.gov/facts-figures/population-demographics

Fastest Growth in Next 20 Years: 85 and Older



IMPACTS

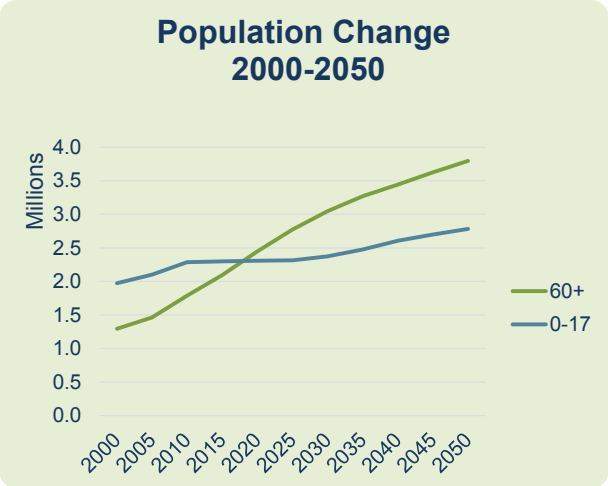
- Increased prevalence of functional limitations, frailty, chronic diseases
- More demand for long-term supports and services

Source: NC Office of State Budget and Management, Standard Population Estimates, Vintage 2021; Population Projections, Vintage 2041, www.osbm.nc.gov/facts-figures/population-demographics

Shifting Demographics

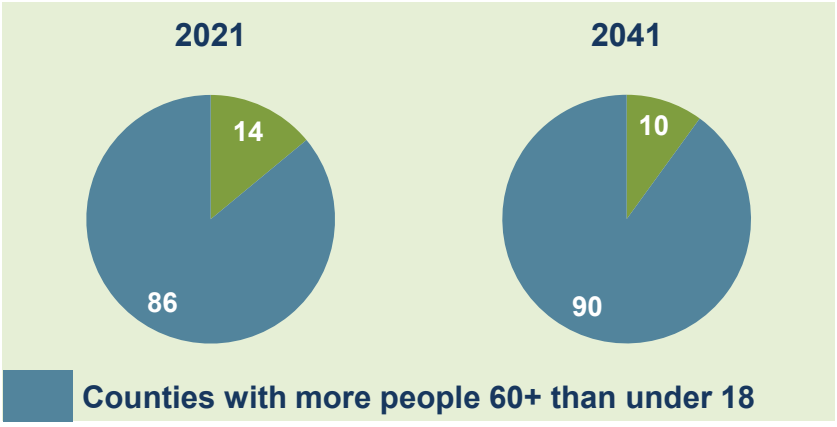
NC has more people 60+ than under 18

In 2021: 86 counties with more 60+ than under 18; 90 counties by 2041



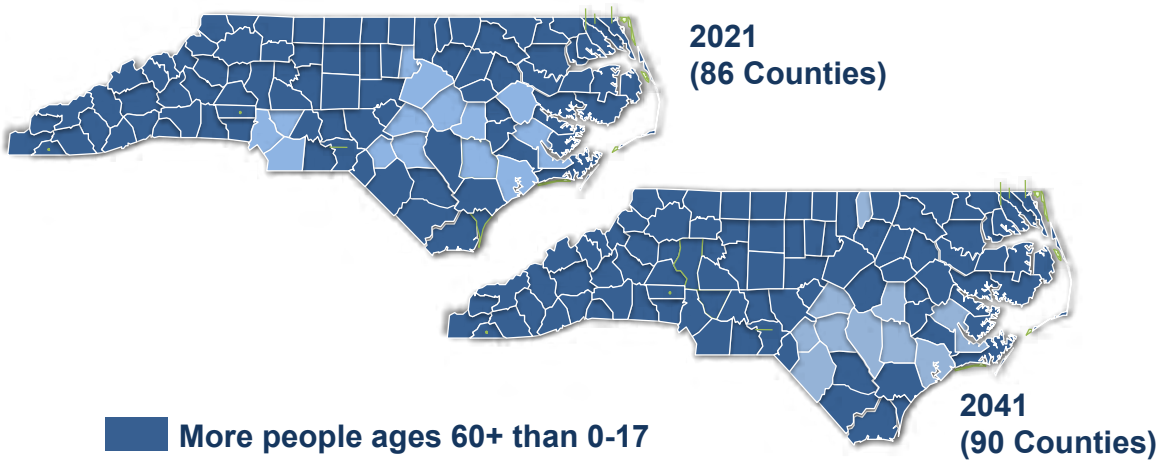
Source: NC Office of State Budget and Management, Standard Population Estimates, Vintage 2021; Population Projections, Vintage 2041, www.osbm.nc.gov/facts-figures/population-demographics

Shifting Demographics, 60+, 2021-2041



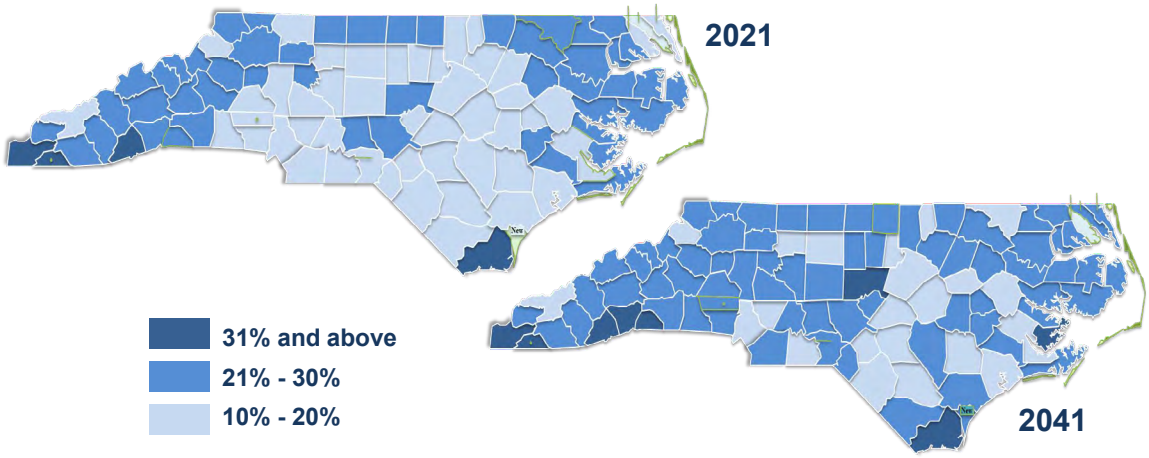
Source: NC Office of State Budget and Management, Standard Population Estimates, Vintage 2021; Population Projections, Vintage 2041, www.osbm.nc.gov/facts-figures/population-demographics

Shifting Demographics, 60+, 2021-2041



Source: NC Office of State Budget and Management, Standard Population Estimates, Vintage 2021; Population Projections, Vintage 2041, https://www.osbm.nc.gov/facts-figures/population-demographics

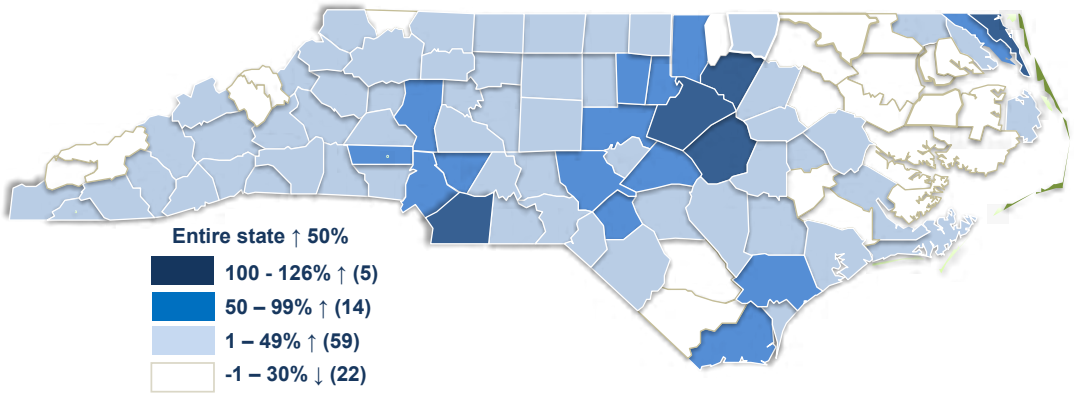
Increasing 65+ Population, 2021-2041



Source: NC Office of State Budget and Management, Standard Population Estimates, Vintage 2021; Population Projections, Vintage 2041, https://www.osbm.nc.gov/facts-figures/population-demographics

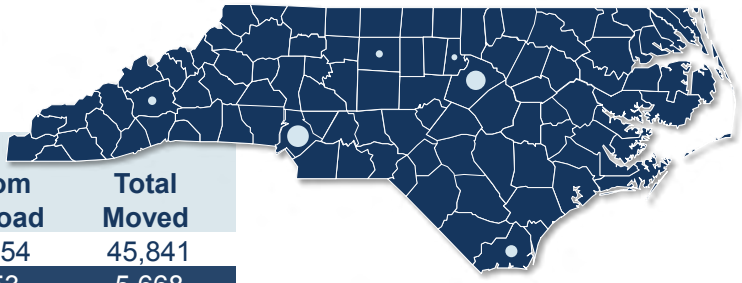
Projected Change in Population 65+ (2021 to 2041)

Many rural counties expected to decline due to out-migration of younger people and natural decrease of older adult population



Source: NC Office of State Budget and Management, Standard Population Estimates, Vintage 2021; Population Projections, Vintage 2041
www.osbm.nc.gov/facts-figures/population-demographics

In-Migration of People 60+ to Metropolitan Areas

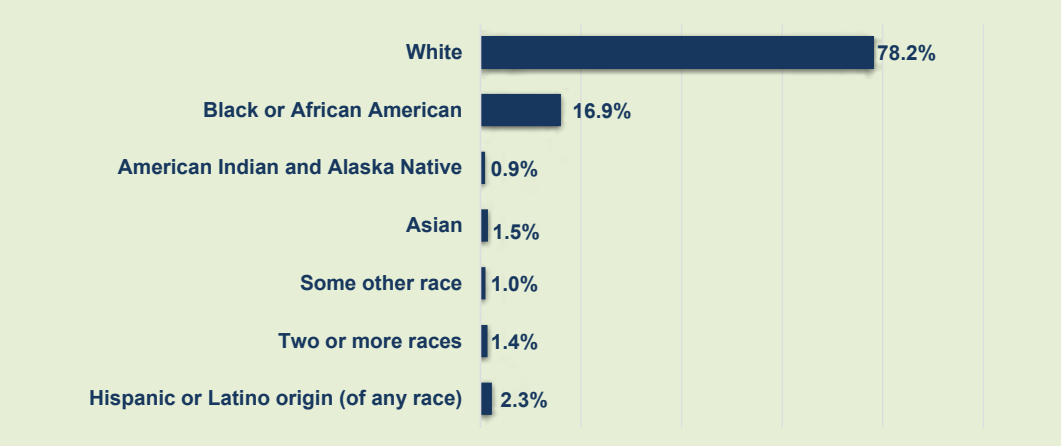


Destination	From Another State	From Abroad	Total Moved
North Carolina	41,287	4,554	45,841
Mecklenburg	4,915	753	5,668
Wake	4,444	597	5,041
Brunswick	1,952	35	1,987
Buncombe	1,586	76	1,662
Guilford	1,489	148	1,637
Durham	1,455	124	1,579

Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table B07001: Geographical mobility in the past year by age for current residence in the United States, https://data.census.gov/cedsci/

Socio-Economic Characteristics, 2021

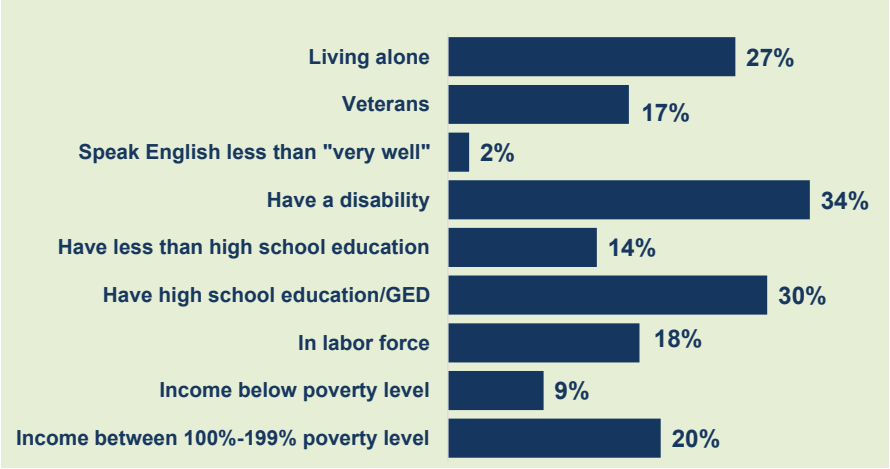
Race/Ethnicity of 65+



* As % of population 65 and older

Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table S0103: Population 65 and over, https://data.census.gov/cedsci/

Characteristics of Adults 65 and Older



*As % of population 65 and older

Older adults **living alone** at risk of **social isolation, loneliness** and **poor health outcomes**

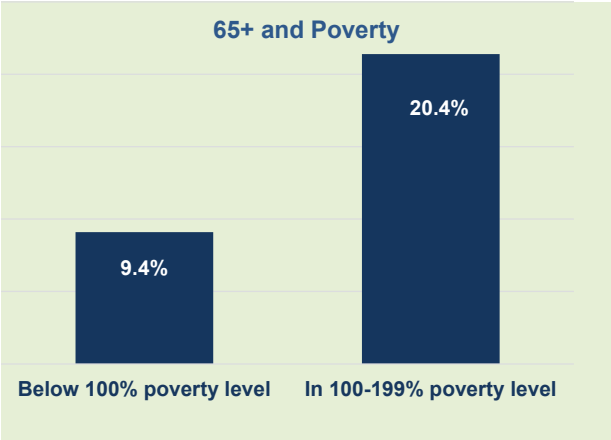
Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table S0103: Population 65 and over; B09020: Relationship by household type (including living alone) for population 65 and over, https://data.census.gov/cedsci/

Poverty Levels, 65+

Nearly **1 of 10** adults 65+ live below poverty*

- $12,996 for individuals aged 65+
- $16,400 per household of two people with householder aged 65+

Older American Act services **provide important safety net for older adults** below and near poverty and help older adults remain in their homes

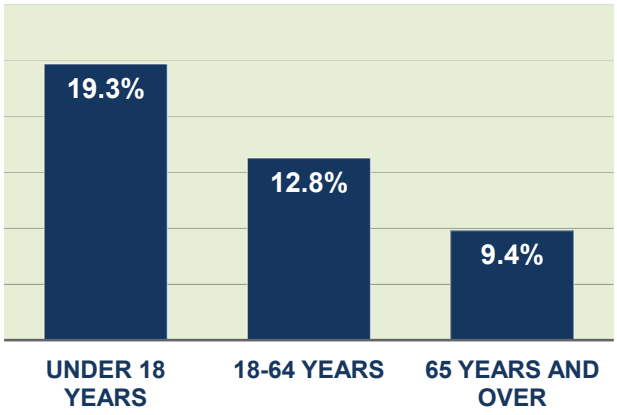


Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table B17024: Age by ratio of income to poverty level in the past 12 months, https://data.census.gov/cedsci/. *Based on 2021 census poverty threshold

Poverty Levels, 65+

Adults 65+ experience lower poverty rates compared to other age groups

Federal programs such as **Medicare, Social Security and Supplemental Security Income** critical to enhancing economic security and reducing poverty rates



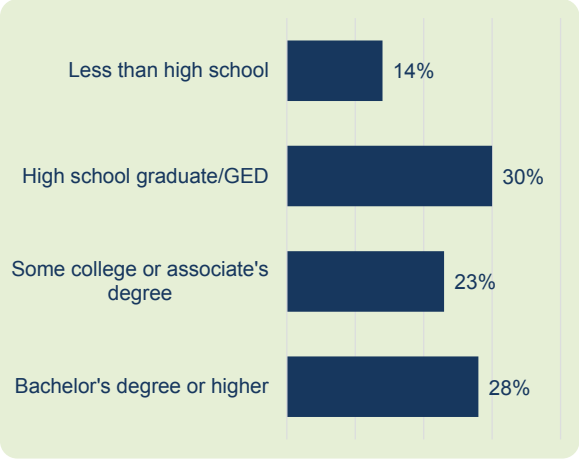
** As a % of age group*

Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table B07001: Geographical mobility in the past year by age for current residence in the United States, https://data.census.gov/cedsci/

Education Level of 65+

Educational levels among 65+ **have risen** in past decade

Higher educational levels associated with higher incomes and **better health outcomes**



* As % of population 65 and older

Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table S0103: Population 65 and over, https://data.census.gov/cedsci/

Labor Force Participation, 65+

Participation rate among 65+ increased from 15% in 2010 to 17% in 2021

People are working longer due to:

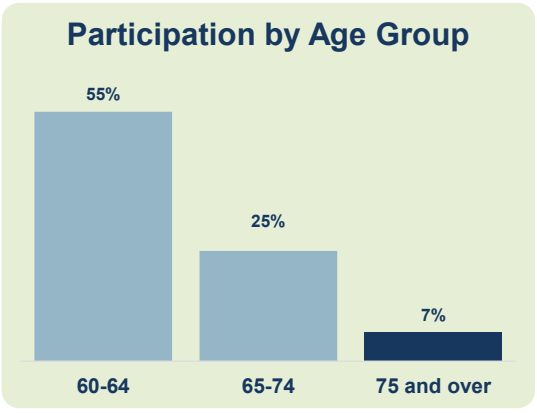
- Sense of purpose
- Being engaged
- Financial responsibilities
- Living longer
- Healthier

In labor force	**17.6%**
Employed	17.0%
Seeking Employment	0.6%
As percent of total civilian labor force	3.2%
Not in labor force	82.4%

** As % of population 65 and older*

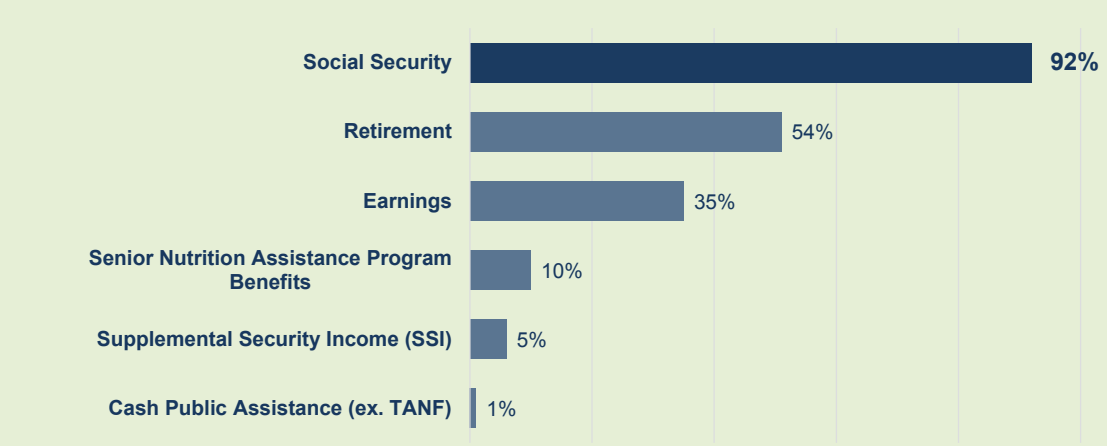
Source: U.S. Census Bureau, American Community Survey 2021 5-year estimates. Table S0103: Population 65 and over, https://data.census.gov/cedsci/

Labor Force Participation



Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table S2301: Employment status, https://data.census.gov/cedsci; American's aging workforce: Opportunities and Challenges. www.congress.gov/115/crpt/srpt191/CRPT-115srpt191.pdf

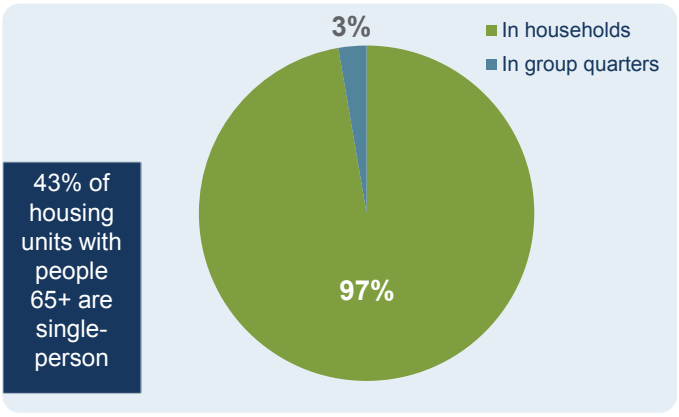
Sources of Income, 65+



** As % of population 65 and older*

Source: U. S. Census Bureau, American Community Survey 2021, 5-year estimates. Table S0103: Population 65 and over, https://data.census.gov/cedsci/

Housing, 65+



43% of housing units with people 65+ are single-person

Aging in place requires livable communities, home modifications, transportation, access to services, health care, and social engagement

Aging population increases demand for home and community-based services

**As % of population 65 and older*

Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Tables S0103; B09020: Relationship by household type (including living alone) for population 65 and over, https://data.census.gov/cedsci/

Women Disproportionately in Group Quarters, 65+

	Total 65+	Institutionalized	Noninstitutionalized
Total	43,515	39,486	4,029
Female	**65%**	**66%**	**50%**

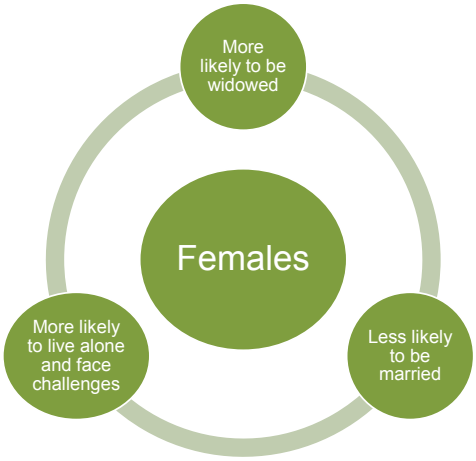
**As % of population 65 and older in group quarters*

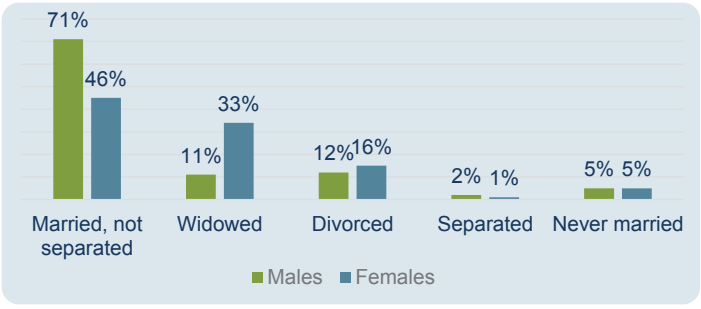
Institutionalized
- Correctional facilities
- Nursing homes
- Psychiatric hospitals
- In-patient hospice facilities, etc.

Non-institutionalized
- Military quarters
- Group homes
- Shelters for homeless people, etc.

Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table S2601A: Characteristics of group quarters population, https://data.census.gov/cedsci/

Marital Status, 65+





**As % of population 65 and over*

Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table S1201. Marital Status, https://data.census.gov/cedsci/

Grandparents Raising Grandchildren Under 18 Years

45% are 60+; of these:

- **59%** are women
- **61%** are white
- **30%** are black or African American
- **31%** have disability
- **38%** are in labor force
- **19%** live below poverty

Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table S1002: Grandparents, https://data.census.gov/cedsci/

Health & Well-Being

Health Characteristics, 65+

34% have disability

83% have one or more chronic diseases

70% had adult flu shot/spray in past 12 months

75% ever had pneumonia shot

72% exercised in past 30 days

7% self-reported poor health

**As % of population 65 and older*

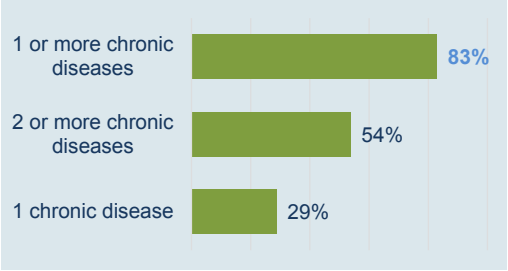
Source: U.S. Census Bureau, American Community Survey 2021, 5-year estimates. Table C18018: Age by number of disabilities, https://data.census.gov/cedsci/; NC State Center for Health Statistics. BRFSS 2021 survey results, https://schs.dph.ncdhhs.gov/data/brfss/survey.htm

Chronic Diseases and Aging

Risk of chronic diseases increase with old age

8 out of 10 people 65+ have one or more chronic diseases

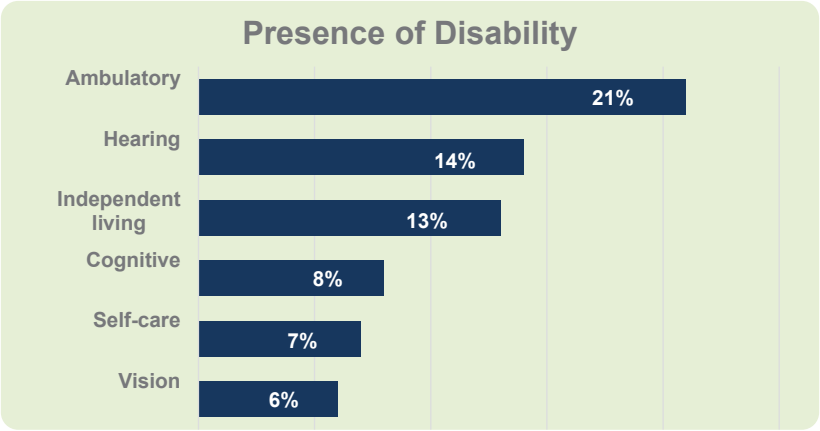
Chronic Disease Self-Management Education programs help people better manage chronic conditions



**As % of population 65 and older*

Source: NC State Center for Health Statistics. Behavioral Risk Factor Surveillance System (BRFSS) 2021 survey results, https://schs.dph.ncdhhs.gov/data/brfss/survey.htm

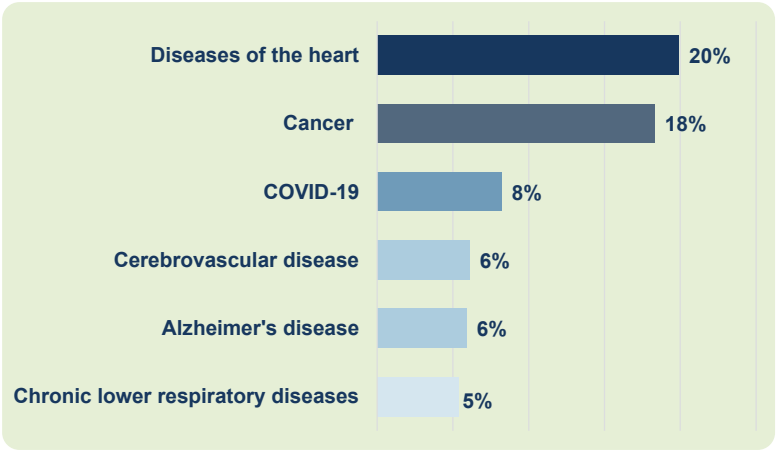
Disability Status, 65+



As % of population 65 and older. Civilian non-institutionalized population only.

Source: U.S. Census Bureau, American Community Survey 2021 5-year estimates. Table S1810: Disability Characteristics, https://data.census.gov/cedsci/; www.ncbi.nlm.nlm.nih.gov/pmc/articles/PMC6873710/

Leading Causes of Death, 65+, 2021



As % of total deaths among population 65 and over

Physical activity, engagement, proper nutrition, clinical preventive services **promote health**

Source: NC State Center for Health Statistics, Leading Causes of Death, https://schs.dph.ncdhhs.gov/interactive/query/lcd/lcd.cfm; www.cdc.gov/chronicdisease/resources/publications/factsheets/promoting-health-for-older-adults.htm

NC Caregivers*, All Ages (2021)

358,000
Number of caregivers

517 Million
Total hours of unpaid care

$7.3 Billion
Total value of unpaid care

Source: Alzheimer's Association: Alzheimer's Disease Facts and Figures report, NC; https://www.alz.org/media/Documents/northcarolina-alzheimers-facts-figures-2022.pdf. *A caregiver is a person who tends to the needs or concerns of a person with short- or long-term limitations due to illness, injury or disability.

BRFSS Survey Responses of NC Caregivers, 65+

17% provided regular care/assistance to friend/family member with health problem/disability during past 30 days

38% provided care for more than 5 years

48% provided weekly care up to 8 hours and 30% for 40+ hours

28% cared for people with disabilities; **31%** for people with hypertension, diabetes and organ failure/disease; **16%** for people with dementia and other cognitive impairment

Source: NC State Center for Health Statistics, BRFSS, NC Caregiver Survey, 2021 According to the Behavioral Risk Factor Surveillance System (BRFSS), NC Caregiver Survey Results 2021

BRFSS Survey Responses of NC Caregivers, 65+

48% managed care recipient's personal care; **75%** managed personal tasks

79% of care recipients were 65+

17% provided care to parent/parent-in-law; **14%** to child/grandchild; **38%** to spouse (include in-law); **17%** to grandparent/other relative; **14%** to non-relative

Source: NC State Center for Health Statistics, BRFSS, NC Caregiver Survey, 2021 According to the Behavioral Risk Factor Surveillance System (BRFSS), NC Caregiver Survey Results 2021

Caregiving in NC (2021)

Need for caregivers significantly increases as population ages

Caregiving is rewarding but caregivers are at risk of increased stress, depression, and poor health outcomes

Family Caregiver Supports provides needed supports and services to caregivers

Family Caregiver Support Program	Lifespan Respite	Project CARE	Trualta NC Caregiver Platform

Source: https://www.ncdhhs.gov/assistance/adult-services/family-caregiver-support

Social Isolation and Loneliness

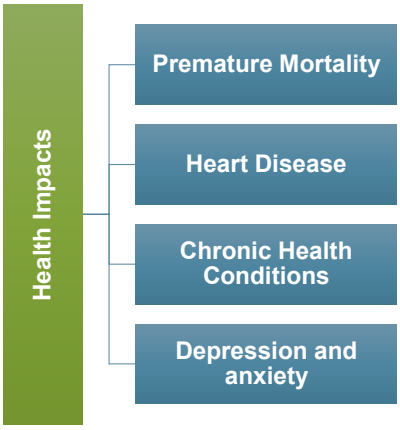
Associated with poor health outcomes and increased Medicare spending

27% of those 65+ live alone

~43% of those 65+ are unmarried

(widowed, never married or divorced)

Many aging services address isolation and promote well-being



Source: www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks **U.S. Census Bureau, American Community Survey 2021, 5-year estimates .09020: Relationship by household type (including living alone) for population 65 and over. Table S1201. Marital Status,** https://data.census.gov/cedsci/ ***Note: Social isolation is the objective physical separation from other people (living alone), while loneliness is the subjective feeling of being alone or separated.***

Older Adults and Civic Engagement:

AmeriCorps Seniors Programs in North Carolina, 2021

Members and Volunteers

- Prepare students for jobs
- Help those impacted by COVID-19
- Connect veterans to services
- Fight opioid epidemic
- Help seniors live independently
- Rebuild communities after disasters
- Lead conservation and climate change efforts

Source: National Service in North Carolina https://americorps.gov/sites/default/files/upload/state_profiles/pdf_2022/NC%20Combined.pdf

Older Adults and Civic Engagement:

AmeriCorps Seniors Programs in North Carolina, 55+, 2021

NC Foster Grandparents served **1,950+** young people with special needs

NC Seniors Companions provided independent living support to **670+** individuals

Source: National Service in North Carolina https://americorps.gov/sites/default/files/upload/state_profiles/pdf_2022/NC%20Combined.pdf

Benefits Reported After Volunteering One Year

- Decreased anxiety and depression
- Decreased loneliness and social isolation
- Enhanced physical activity
- Higher life satisfaction

Senior volunteers reap health benefits, American Association for Retired Persons www.aarp.org/health/healthy-living/info-2017/health-benefits-volunteering-seniors-fd.html

Glossary

Disability - A long-lasting physical, mental, or emotional condition that makes it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering.

- **Ambulatory** – Serious difficulty walking or climbing stairs
- **Independent living** – Difficulty doing errands alone
- **Hearing** – Deaf or having serious difficulty hearing
- **Cognitive** – Difficulty remembering, concentrating or making decisions
- **Self-care** – Difficulty bathing or dressing
- **Vision** – Blind or serious difficulty seeing even with glasses

Household - A household includes all the people who occupy a housing unit as their usual place of residence. Household types are arranged into 2 groups. A ***family household*** contains at least 2 people, the householder and at least 1 other person related to the household by birth, marriage or adoption. A ***nonfamily household*** may contain only one person, the householder or additional people who are not relatives of the householder.

Householder - The person, or one of the people, in whose name the home is owned, being bought, or rented.

Income - "Total income" is the sum of the amounts reported separately for wages, salary, commissions, bonuses, or tips; self-employment income; interest, dividends, net rental income, royalty income, or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); any public assistance or welfare payments from the state or local welfare office; retirement, survivor, or disability pensions; and any other sources of income received regularly such as Veterans' (VA) payments, unemployment compensation, child support, or alimony.

Labor force - The labor force includes all people classified in the civilian labor force, plus members of the U.S. Armed Forces (people on active duty with the United States Army, Air Force, Navy, Marine Corps, or Coast Guard). The Civilian Labor Force consists of people classified as employed or unemployed.

Life expectancy - is the average number of additional years that someone at a given age would be expected to live if current mortality conditions remained constant throughout their lifetime

Marital status - Now Married, Except Separated includes people whose current marriage has not ended through widowhood, divorce, or separation (regardless of previous marital history). The category may also include couples who live together or people in common-law marriages if they consider this category the most appropriate. In certain tabulations, currently married people are further classified as "spouse present" or "spouse absent." In tabulations, unless otherwise specified, "now married" does not include same-sex married people even if the marriage was performed in a state issuing marriage certificates for same-sex couples. Separated Includes people legally separated or otherwise absent from their spouse because of marital discord. Those without a final divorce decree are classified as "separated." This category also includes people who have been deserted or who have parted because they no longer want to live together, but who have not obtained a divorce.

Median income - The median income divides the income distribution into two equal groups, one having incomes above the median, and other having incomes below the median.

Metropolitan Area - A metro area contains a core urban area of 50,000 or more population. Each metro area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core.

Poverty - The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If the total income for a family or unrelated individual falls below the relevant poverty threshold, then the family (and every individual in it) or unrelated individual is considered in poverty. The poverty threshold (2020) for a person 65 and older is $12,413 and for two people (householder aged 65 and older) is $15,644.

Race/Ethnicity - The Census Bureau collects racial data in accordance with guidelines provided by the U.S Office of Management and Budget. The data is based on self-identification in which residents choose the race or races with which they most closely identify. *Hispanic or Latino* refers to an ethnic category, a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.

Rural - All territory, population, and housing units located outside of urbanized areas and urban clusters.

Urban - For the 2010 Census, an urban area will comprise a densely settled core of census tracts and/or census blocks that meet minimum population density requirements, along with adjacent territory containing non-residential urban land uses as well as territory with low population density included to link outlying densely settled territory with the densely settled core. To qualify as an urban area, the territory identified according to criteria must encompass at least 2,500 people, at least 1,500 of which reside outside institutional group quarters.

Definitions of other terms in report available in glossary of American Community Survey at: http://factfinder.census.gov/home/en/epss/glossary_a.html

G. AGE MY WAY NC DATA

A detailed survey conducted by the AARP Research Team/Department May 1 through August 26, 2022, asked North Carolinians ages 45 plus how their communities, counties and rural areas are meeting the needs of the state's rapidly growing population of older adults. The survey collected results from 3,209 respondents with a 1.8% margin of error. Most survey respondents were homeowners (88%) living in single family houses (81%).

Information from the survey is being used to identify and evaluate areas of concern when it comes to aging in the state. By 2025, there will be more North Carolina residents ages 60 and older than those under age 18.

Key Findings

Generally, there is high satisfaction when it comes to "loving where you live." However, the ability to live independently while aging is a primary concern. Most people (88%) said that it is important to live in their community as long as possible.

- Nearly all, (99%) of the survey respondents said that it is important to live independently in their own home as they age.
- A majority, (76%) rated their current community as an "excellent, very good or good" place to live as they age.
- While 53% said they are likely to stay in their current residence and never move, 17% said they would relocate within their community and 30% said they would relocate elsewhere.
- The two major factors for moving are having a house that allows people to live independently as they age, and to be able to afford the cost of maintaining their current residence.

Other significant factors for moving include:

- Personal safety and security concerns;
- Wanting to move to an area with better healthcare facilities;
- Wanting to be closer to family;
- Needing more access to public transportation;
- Wanting to live in an area with a lower cost of living;
- Wanting to live in an area with more opportunities for social interaction.

Support for independent living

Living independently requires support including transportation options, well-designed homes and public spaces, access to health care and home health, and the ability to participate in community life.

Mobility and access to public transportation

- Only 22% of respondents ranked access to public transportation as "excellent, very good or good."
- Only 26% ranked it as affordable with a similar number (26%) saying there are special transportation services for older adults and those with disabilities.
- When it comes to mobility, respondents gave high ranks to easy-to-read traffic signs, and low ranks to the availability of separate paths for cyclists and pedestrians in their community.

Healthcare

- 38% of respondents said that access to well-trained certified home health care providers was "excellent, very good or good," and only 28% said that care is affordable.

Also ranked low, was the availability of affordable home care services such as personal care and housekeeping.

Needed services

When it comes to their greatest needs involving home maintenance, participants ranked highest the availability of home repair contractors who are trustworthy, do quality work and are affordable, and lowest for home repair service for low-income and older adults that help with things like roof and window repair.

When rating their own community, the highest marks were given to well-maintained houses, hospitals and health care facilities, as well as public buildings that have restrooms accessible to people with different physical abilities. The lowest rankings were for benches used for resting in public areas like parks, along sidewalks and around public buildings.

Social Participation

Social isolation has a negative health impact and is identified as a factor for why a person has to relocate as they age.

- 25% of the survey respondents said they feel isolated from others and 31% said they have a lack of companionship.

More on the Survey Methodology

A team of community and state partners including NC Department of Health and Human Services, Division of Aging and Adult Services; and Hometown Strong steered the Age My Way NC survey implementation.

AARP provided guidance on the format and survey tool.

The team of community partners distributed a link and a QR Code to their organizational contacts so that participants could access the survey online. Participant groups contacted included major providers of aging services, other local nonprofits, recreation facilities, universities, and others. Additionally, paper copies were accessed through libraries and senior centers.

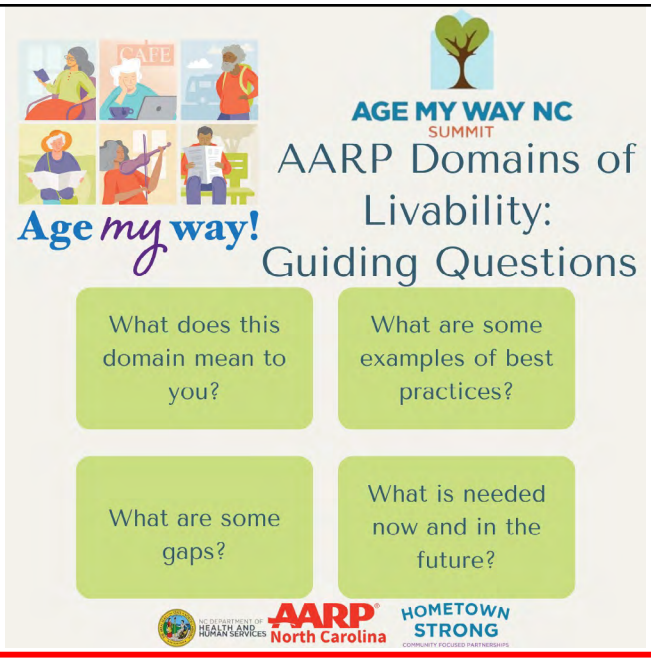
The purpose of the Age My Way Summit was to improve older adults' quality of life by promoting the development of safe, accessible and vibrant environments known as livable communities. Livable communities' policies address issues such as land use, housing, transportation and broadband — all of which facilitate aging in place and encompass the twelve domains of livability.

During the facilitated table discussions, 180 subject matter experts, in groups, brainstormed ideas, solutions, creative services, and programs through 4 guiding questions.

LIVABILITY DOMAINS REPORT - FACILITATED TABLE DISCUSSION

Age My Way NC Planning Committee

AGE MY WAY NC
SUMMIT



GUIDING QUESTIONS

AGE MY WAY NC
SUMMIT

HOUSING

What does this domain mean?

AGE MY WAY NC
SUMMIT

HOUSING

- Best Practices: surveying community needs, committed planners, data, infrastructure and growth preparedness, design standards, age-friendly developers, strategic leasing, locally owned land-acquisition programs, sustainable homes, retirement communities, tiny homes, & mixed/integrated communities
- Gaps/Barriers: public participation, strategic planning, affordability/funding, equity, mobility, zoning of communities, age-consciousness in new housing, housing types (1 level), permit requirements lacking design aspects to keep all safe, & accurate information
- Current/Future Needs: reassessment of affordability, simplifying process, more investments in repair and preservation, more public participation and engagement, & changes in beginning of building processes

AGE MY WAY NC
SUMMIT

OUTDOOR SPACES & BUILDINGS

What does this domain mean?

AGE MY WAY NC SUMMIT

OUTDOOR SPACES & BUILDINGS

- Best Practices: trail assets and gaps to inform a trail inventory, needs assessments, data on park usage, connecting trails to tourism, advertising trails based on user, accessible trails, placemaking, & age-friendly practices/adaptations
- Gaps/Barriers: information, design of parks, directions/signs, maintenance, equitable opportunities for trails, wheelchair accessible trails, handicap accessible doors, & seating *within* stores
- Current/Future Needs: conversations that include multiple sectors, messaging targeting older adults, integration of age-friendly features for commercial development & state investments to supplement funding in rural areas

AGE MY WAY NC SUMMIT

TRANSPORTATION

What does this domain mean?

AGE MY WAY NC SUMMIT

TRANSPORTATION

- Best Practices: consumer direction, micro transit, & escort service for people with disabilities on transit
- Gaps/Barriers: policies for changing needs, drivers/workforce, availability of services, routes that extend outside city limits, reliability, education on resources, costs/funding coordination, independence with options, & supportive services for language/cultural barriers
- Current/Future Needs: technology usage that connects resources for transportation, more on demand in rural areas, autonomous cars, education for municipalities and HOA's about maintenance of sidewalk, lightings, big signs, and infrastructure for mobility

AGE MY WAY NC SUMMIT

COMMUNICATION AND INFORMATION

What does this domain mean?

technology
timeliness
signers
services
openness
communication
access
advocacy
awareness
support
training
education
resources
connecting
preparedness
regulations
availability
broadband
standards
policies
newsletters
intergenerational
inclusivity
literacy
print
consistency
outreach
media
sources
understanding
messaging



AGE MY WAY NC SUMMIT

COMMUNICATION AND INFORMATION

- Best Practices: Neighborhood associations, newsletters, social media, intergenerational support, & trainings
- Gaps/Barriers: access to broadband (particularly in rural areas), language barriers, vulnerability to scams, misinformation, reluctance to use technology, & social isolation
- Current/Future Needs: accurate/timely/consistent information, computer/smart phone trainings, intergenerational connections, AARP digital literacy, signers for hearing impairments, alternative broad technologies, & continue advocacy

AGE MY WAY NC SUMMIT

RESPECT AND SOCIAL INCLUSION

What does this domain mean?

heard valued
multi-generational
connectedness
accessible
understood
stability participate
open aging included recognized
place dignity intergenerational
representation seen
inclusive

AGE MY WAY NC
SUMMIT

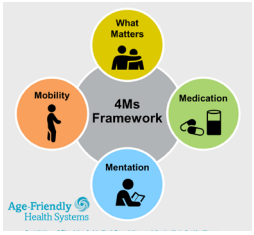
RESPECT AND SOCIAL INCLUSION

- Best Practices: Ensuring people can see themselves as part of the Master Aging Plan, "extra efforts" to reach a representative group of older adults in the survey, "Hope NC" – inclusive and accessible housing for older adults & IDD, UNC Partnership for Aging, grandparents raising grandchildren, & improved planning and zoning practices
- Gaps/Barriers: weak leadership, not reaching the right people, & affordability of accommodations
- Current/Future Needs: Reach into State/Federal government retiree association for intergenerational connections, campaigns to promote multi-generational living, remove stigma, & reevaluate resources to assure equity in allocation of public resources

AGE MY WAY NC
SUMMIT

HEALTH SERVICES & COMMUNITY SUPPORTS

What does this domain mean?



AGE MY WAY NC SUMMIT

HEALTH SERVICES & COMMUNITY SUPPORTS

- Best Practices: dedicated funding to highest priorities, living wage for essential workers, programs to support caregivers, sensitivity training, social workers to replace law enforcement response, incentives to rural medical professionals, investments into preventative measures, & age-friendly hospitals
- Gaps/Barriers: society does not value support for this phase of life, ageism, disparities in urban vs. rural, flexibility in grant requirements, distribution of funding, locations that do not accept Medicare, navigating complex systems, waiting list, & language barriers
- Current/Future Needs: intergenerational support and considerations, education at younger ages, breaking down silos, more cross-sector collaboration, bridging gap between community-based services and clinical services, community focus, continuity of care, higher wages for healthcare workers, support for unpaid caregivers, & insurance reform, funding/sustainability within funding sources

AGE MY WAY NC SUMMIT

SOCIAL PARTICIPATION

What does this domain mean?

AGE MY WAY NC SUMMIT

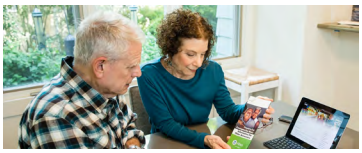
SOCIAL PARTICIPATION

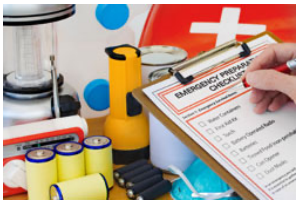
- Best Practices: Senior Centers, evidence-based programs, faith-based programs, phone calls for homebound, & transportation services
- Gaps/Barriers: distance in rural areas, lack of resources to provide services, waitlists, lack of broadband,& accessible transportation
- Current/Future Needs: transportation solutions, expand broadband, communication about opportunities for engagement, engage younger generations, volunteerism to help older adults, & caregiving workforce

AGE MY WAY NC SUMMIT

EMERGENCY PREPAREDNESS

What does this domain mean?





AGE MY WAY NC SUMMIT

EMERGENCY PREPAREDNESS

- Best Practices: Emergency drills, DSS, emergency operation centers, task force, access to equipment, mutual aid, & Hurricane expo for information
- Gaps/Barriers: not all places have standards and regulations, volunteers to staff emergency shelters, transportation, access to shelters, communication,& broadband access
- Current/Future Needs: continue having programs of affordable broadband, continue communication with older adults, & new roadways and superstreet planning

AGE MY WAY NC SUMMIT

ELDER ABUSE

What does this domain mean?

AGE MY WAY NC SUMMIT

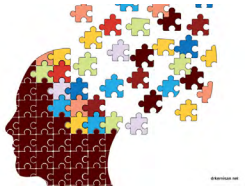
ELDER ABUSE

- Best Practices: advocacy in long-term care, ombudsman, & community education
- Gaps/Barriers: not enough caregivers/healthcare works, case management, comfortability in recognizing elder abuse, not reported, unspoken abuse from frustrated caregivers, & social isolation
- Current/Future Needs: changes to the statute & resources to both caregivers and care recipient

AGE MY WAY NC SUMMIT

DEMENTIA-FRIENDLY

What does this domain mean?



AGE MY WAY NC SUMMIT

DEMENTIA-FRIENDLY

- Best Practices: training/sensitivity, NCCARE360, dementia care units, support groups, memory binder, informal and well-equipped advocates, training entire staff, business training programs, hands-on activities, technology-based services, & social interaction
- Gaps/Barriers: financial barriers, community caregiver support/respite, & accessibility of support and education
- Current/Future Needs: education to community, better Mental Health services, redefine dementia, leveraging different groups, dementia training modules, & prioritizing funding

AGE MY WAY NC SUMMIT

TAKEAWAY/COMMON THEMES ACROSS ALL DOMAINS

- Reassess affordability and prioritizing funding
- Communication: Education/Training/Awareness
- Cross-sector collaboration and breaking down silos
- Public participation & increased engagement
  - Intergenerational and multi-generational approaches
  - Community-focused approaches
- Equity
  - Rural vs Urban
  - Disparities: racial/Ethnic populations
  - Redefining Aging and reframe messaging
- Streamlining processes and infrastructures
  - Implementing changes earlier in the process

AGE MY WAY NC
SUMMIT

H. HISTORY OF PLANNING FOR AN AGE-FRIENDLY NC

This document provides an overview of the Age-Friendly NC initiative launched by the North Carolina Department of Health and Human Services (NCDHHS) to create communities that are inclusive and supportive of older adults.

HISTORY OF PLANNING FOR AN AGE-FRIENDLY NORTH CAROLINA

North Carolina has a long and strong history of planning for our aging population. Many organizations and individuals have contributed to help identify and address challenges and opportunities relevant to older adults, as well as their families and communities.

This timeline highlights milestones to support aging well in North Carolina. It is incumbent on us to build upon this work and ensure that North Carolina is age-friendly from Manteo to Murphy.

YEAR MILESTONE

1950 – President Harry Truman initiated the first National Conference on Aging

1956 – Special Staff on Aging was established within the Office of the Secretary of Health, Education, and Welfare (Federal Council on Aging) to coordinate responsibilities for aging.

1961 – The first White House Conference on Aging was held in Washington D.C.

1965 – The Older Americans Act was signed into law and called for the creation of State Units on Aging.

1971 – Second White House Conference on Aging was held.

1972 – Older Americans Act was amended to create a national nutrition program for older adults.

"A quiet revolution has taken place in the age structure of American society…. Increased life expectancy is one of the greatest social achievements of our times… The problems of aging are universal….Aging is not something that happens to somebody else."

– Excerpts from statement of leading gerontologists endorsing Senator Kennedy's "Positive Response to the Challenge of Aging" [October 1960]

1973 – Older Americans Act was amended to establish Area Agencies on Aging, with a role in planning for an aging population.
– Governor's Advisory Council on Aging was established.

1977 – North Carolina Division of Aging was established in State law.

1980 – NC Division of Aging held its first annual Summer School of Gerontology to increase participants' knowledge and skills to better serve older North Carolinians.

1981 – Third White House Conference on Aging was held.

1983 – NC General Assembly established a Bill of Rights for residents of nursing homes and enacted legislation creating the Nursing Home and Adult Care Home Community Advisory Committees.

1984 – NC General Assembly established a Bill of Rights for residents of adult care homes (assisted living).

1985 – NC Division of Aging developed Performance Based Contracting System for the Area Agencies on Aging (working with consultant Alan Ackman).

1986 – North Carolina Insurance Commissioner created the Seniors' Health Insurance Information Program (SHIIP) as one of the nation's first efforts to link older adults with information about their health insurance.

1987 – NC General Assembly established the North Carolina Study Commission on Aging. [Article 21 of Chapter 120 of the NC General Statutes]
– NC General Assembly supported the first major infusion of State funds into the Aging Network to strengthen community-based assistance.

1988 – The UNC Center for Aging Research and Educational Services produced *Warmth in Their Winter*, a policy document to guide Social Services in assisting older adults and adults with disabilities.

1989 – NC General Assembly called for a regularly updated plan for serving older adults [State Law 1989-52] and an inventory of data sets to support such planning [State Law 1989-695].
– NC General Assembly called for the State Department of Human Resources to create an Advisory Committee on Home and Community Care.
– NC State Center for Health Statistics issued a report on *Health of the Elderly in North Carolina: Population at Risk and Patterns and Trends in Mortality*.

1990 – The Americans with Disabilities Act was signed into law.

1991 – First state-mandated Aging Plan was completed (1991-1993).

1992 – Funded by the Kate B. Reynolds Health Care Trust, a report was completed on strategic planning for aging projects in Cleveland, Durham, Pamlico and Surry counties.
– NC General Assembly established the Home and Community Care Block Grant, which includes a local planning component.

1993 – The second State Aging Plan, *A Unified Social and Health Services System for Older Adults*, was released.
– NC Division of Aging began collecting and presenting data from various state agencies to support local planning for the aging population and to help guide use of the Home and Community Care Block Grant funds.
– NC General Assembly created the North Carolina Senior Tar Heel Legislature to help assess the legislative issues and needs pertaining to older adults.

1995 – NC General Assembly moved the State Aging Plan from every odd numbered year to every other odd numbered year. [State Law 1995-253]
– The third State Aging Plan, *An Opportunity to Shape Our Future – A Guide for Successful Aging* in the 1990s, was released.
– The fourth White House Conference on Aging was held. Regional and local forums were held in North Carolina prior to the conference to help inform North Carolina's delegates.

1996 – The NC Division of Aging's website debuted, the first site within the Department of Health and Human Services. The division was also the 9th State Unit on Aging to have a presence on the Internet and received a 1st Choice rating from the US Administration on Aging.

1997 – UNC Center for Aging Research and Educational Services produced a series of reports for the NC Division of Aging focused on baby boomers: *Baby Boomers at Mid-Life – The Future of Aging in North Carolina* and *Future of aging in North Carolina: Responding to the Challenges and Opportunities Presented by Baby Boomers at Mid-Life*. Numerous stakeholder meetings were held across the state to share the reports' information.

1998 – The NC Agency for Public Telecommunications dedicated one of its *Inside NC* programs to *Aging Issues*.
– NC's first four-year state aging plan, *North Carolina, A Leader in Aging*, was completed.
– NC Governor's Advisory Council on Aging held a forum and produced report on *Information and Assistance*.
– The National Academy on an Aging Society produced its report *Demography Is Not Destiny*. Revised 2005.

1999 – NC joined in celebrating the *International Year of Older Persons* with an informational and educational campaign, a seminar for journalists on "Life in an Older America" and a conference.

"The aging of the state's population represents an unparalleled, but urgent, policy and program challenge to both public and private organizations to ensure that the needs of the aged and their human resource potential are adequately addressed." – Remarks from Governor Hunt's 1999 proclamation

2000 – NC Governor's Advisory Council on Aging held a forum and issued report on *Serving Older Adults in Rural North Carolina: Meeting the Challenge*.

2001 – NC Institute of Medicine's Task Force on Long Term Care (LTC) completed its report, prompting the NC Division of Aging and Adult Services to develop and institute a methodology that evaluated local home and community-based services and supports to aid in developing county LTC services plans.
– WUNC-FM held a series of 17 programs focused on *North Carolina Voices: The State of Aging*.
– The NC Agency for Public Telecommunications dedicated an *OPEN/net* program to *Aging*.
– NC Division of Aging and Adult Services initiated the *Ann Johnson Institute for Senior Center Management*.
– NC Division of Aging and Adult Services was funded by the US Administration on Aging to participate in a multi-year national demonstration *Performance Outcome Measures Project (POMP)* focused on Older Americans Act-funded services.

2002 – NC Task Force on Aging and Developmental Disability: *A Blueprint for Change* – led by Appalachian State University.

2003 – State Divisions of Aging and Adult Services and Public Health produced in-depth publication, *A Health Profile of Older North Carolinians*.
– NC Aging Services Plan for 2003-2007, The Aging of North Carolina, was released.

2005 – The *fifth White House Conference on Aging* was held.
– UNC Institute on Aging produced a report on *Gender, Race, and Class: Enduring Inequities in Later Life – A North Carolina Perspective*.
– NC Division of Aging and Adult Services presented Adult Protective Services Task Force report to NC Study Commission on Aging.
– NC Division of Aging and Adult Services, Area Agencies on Aging and some local aging providers produced and supported use of various tools to aid livable and senior-friendly planning.

"Our collective goal is to meet the challenges of an aging society by drawing upon the talents and resources of active seniors, enhancing services for vulnerable seniors, valuing diversity while addressing disparity, being responsible stewards of resources, and helping baby boomers prepare for their future."

– Remarks of Carmen Hooker Odom, Secretary, NC Department of Health and Human Services, in introducing the 2003 Plan.

2006 – NC Division of Aging and Adult Services and UNC Institute on Aging held a State Conference on Aging.
– NC Department of Correction issued *Aging Inmate Population Study*.
– NC Division of Aging and Adult Services provided an overview to Regional Aging Advisory Councils on *NC's Development of Comprehensive and Integrated Planning for Aging*.
– NC Division of Aging and Adult Services worked with the NC Association of County Commissioners to promote participation in a nationwide survey, "*The Maturing of America – Getting Communities on Track for an Aging Population.*"

2007 – NC Aging Services Plan for 2007-2011, *Putting the Pieces Together*, was completed.

"Some may view the unprecedented growth of the older population as a risk to the State... Still, a mature population also brings with it knowledge, experience, civic-mindedness, and other resources critical to the State's social capital for improving the well-being of all." – *Excerpt from 2007 State Aging Plan*

– NC Division of Aging and Adult Services began producing a series of "Aging Planning Bulletins" to share vital information with local citizen leaders to help bring about significant progress.

2008 – NC Division of Aging and Adult Services promoted "Building Livable and Senior-Friendly Communities" and presented eight essential components to help communities and organizations assess their readiness for an aging population: physical and accessible environment; healthy aging; economic security; technology; safety and security; social and cultural opportunity; access and choice in services and supports; and public accountability and responsiveness.
– At the request of the NC General Assembly, the NC Division of Aging and Adult Services examined, profiled and offered recommendations on the aging population of six counties, using its livable and senior-friendly conceptual framework.

– The *North Carolina Medical Journal* dedicated its September/October issue to the topic "Healthy Aging in North Carolina."
– Governor's Advisory Council on Aging's report on *North Carolina's Aging Workforce* was produced by the UNC Institute on Aging.
– NC Department of Health and Human Services' *Respite Care Study Report* was released.
– NC Division of Medical Assistance issued a report on *Pilot Program/Medicaid Dual Eligible Special Needs Plan*.

"North Carolina is in the midst of a significant demographic transition as the baby boomers approach retirement age in the latter part of this decade. The time to chart an effective course for Livable and Senior-Friendly Communities is NOW… The future interests of older adults, their families, and communities are at stake."

– Remarks of Dennis Streets, Director of NC Division of Aging and Adult Services, 2006-2014

2009
– North Carolina Disability and Elderly Emergency Management report was completed and presented through statewide training. This work was led by the NC Department of Crime Control and Public Safety and NC Department of Health and Human Services.
– NC Division of Services for the Deaf and Hard of Hearing issued report on *Impact of Hearing Loss in Older Adults in North Carolina*.
– NC Department of Health and Human Services' report on *Group Respite Study* was completed.
– NC Division of Public Health reported on Burden of Unintentional Falls in NC.
– NC Center for Public Policy Research published journal issue on aging: *The Art of Aging, Our Elders, Our State*.
– NC Department of Health and Human Services reported on the *Public-Private Long-Term Care Partnership Program*.

2010
– Governor Perdue issued executive order (#54) asking state agencies to assess their readiness to serve and work with NC's aging population and encouraged local governments and the private sector to do the same.
– NC Division of Public Health released report on Older Adult Injuries in North Carolina: 2004-2007.

"The challenge of an aging population requires creative solutions – and innovative thinking…
Our seniors and families are doing their part to make NC better – day in and day out.
So we must continue to do our part in making NC the state for Living Wise and Aging Well."

– Remarks of Governor Perdue at the 2010 Governor's Conference on Aging

2011
– NC General Assembly ended NC Study Commission on Aging. [SL 2011-291, Section 1.6]
– NC Conference on Aging held with the theme, "The Community Response: Implementing the Plan for a Livable, Senior Friendly North Carolina."
– NC Aging Services Plan for 2011-2015, *Living Wise and Aging Well*, was completed
– NC Division of Aging and Adult Services produced *A Profile of People Age 60 and Over [in] North Carolina*.
– New NC Mental Health and Aging Coalition held its first meeting.
– NC Department of Health and Human Services reported on *Project CARE (Caregiver Alternatives to Running on Empty)*.

2012
– NC State Center for Health Statistics reported on *Trends in Key Health Objectives for North Carolina and the Nation: A Report from the Behavioral Risk Factor Surveillance System*.

2014
– NC Institute on Aging held series on *Aging in Community: Planning for Our Future*.
– NC Division of Public Health reported on Elder Suicide in North Carolina [2010-2014].
– NC General Assembly Program Evaluation Division report: *Overnight respite pilot at adult day care facilities perceived as favorable, but lacked objective measures of success*.
– NC Division of Medical Assistance's *PACE Program Initial Study Report* was released.

2015 – NC Aging Services Plan for 2015-2019 was completed. Theme: *Booming Forward: Working Together to Improve Lives*.
– The sixth White House Conference on Aging was held.
– NC Department of Health and Human Services' Final Report on the *PACE Program (Program of All-Inclusive Care for the Elderly)* released.

"We have to work to do more to ensure that every older American has the resources and the support that they need to thrive…. [W]e need to recommit ourselves to finishing the work that earlier generations began – make sure this is a country that remains one where no matter who you are or where you started off, you're treated with dignity, your hard work is rewarded, your contributions are valued, you have a shot to achieve your dreams whatever your age….That's the America we're all working for." – Remarks of President Obama in beginning the 2015 Conference

2016 – The NC Institute of Medicine's Task Force on Alzheimer's Disease and Related Dementias completed *A Strategic Plan for Addressing Alzheimer's Disease and Related Dementias*.

2018 – NC Department of Health and Human Services reported on *Pilot Program/Increase Access to Public Benefits For Older Dual Eligible Seniors*
– NC Department of Health and Human Services reported on *PACE Program Expansion Study*.
– NC Division of Aging and Adult Services launches Adult Protective Services (APS) Improvement Plan with stakeholder Envisioning Sessions

2019 – NC State Aging Plan (2019-2023) was released, with theme of *An Age of Opportunity*.
– NC Division of Public Health presented report on *Elder Suicide in North Carolina [2013-2017]*.

2020 – BOLD Act Grant enabled NC to pursue the federal CDC BOLD – Healthy Brain Initiative and to build a NC public health infrastructure that addressed Alzheimer's Disease and Related Dementias.
– UNC School of Government published manual on *Legal Framework for North Carolina's Elder Protection System*.
– NC Institute of Medicine released *Assuring Accessible Communication for Deaf, Hard of Hearing, and DeafBlind Individuals in Health Settings*.
– NC Division of Aging and Adult Services produced Dementia-Capable North Carolina: Progress Report and North Carolina Dementia-Friendly Communities: Standards & Information for Those Interested in Starting or Growing a Dementia-Friendly Community.
– COVID identified in Washington State nursing homes. Declared a pandemic. NC Division of Aging and Adult Services, as guided by the DHHS Secretary, launches information campaign aimed at older adults

2021 – When vaccine is developed, NC DAAS continues information campaign. DAAS, in partnership with AAAs, launches a vaccine at home program. Federal relief funds are used to serve older adults with added flexibilities

2022 – Age My Way NC Summit is held.
– The Divisions of Aging and Adult Services and Health Benefits are selected to participate in a 10-state learning collaborative to develop a Master Plan on Aging.

2023 – Executive Order 280

Special thanks to Dennis Streets, former director of the NC Division of Aging and Adult Services, for his help in developing this timeline.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Aging and Adult Services

www.ncdhhs.gov/divisions/daas • NCDHHS is an equal opportunity employer and provider. • 5/2023

Executive Order 280

State of North Carolina

ROY COOPER
GOVERNOR

May 2, 2023

EXECUTIVE ORDER NO. 280

NORTH CAROLINA'S COMMITMENT TO BUILDING AN AGE-FRIENDLY STATE

WHEREAS, North Carolina strives to be a great place to grow older, where those who are aging can thrive within families, neighborhoods and communities and be supported to maintain a high quality of life; and

WHEREAS, approximately 1.7 million North Carolinians are age 65 or older and that number is growing; by 2030, one in five will be older than 65; and

WHEREAS, by 2030, and for the first time ever, North Carolina will be comprised of more older adults than children; and

WHEREAS, Alzheimer's Disease and related dementias affect an estimated 300,000 North Carolinians and this number is expected to increase to 400,000 people by 2025; and

WHEREAS, Hometown Strong in the Governor's Office and the North Carolina Department of Health and Human Services (DHHS) partnered with AARP NC in 2022 to conduct the "Age My Way NC" survey statewide to assess the needs and preferences of North Carolinians with regards to aging and the survey results provide data to guide planning; and

WHEREAS, each North Carolina Cabinet Agency works in age-friendly domains and can join with their public and private sector partners to improve the health and quality of life of older people and those with Alzheimer's Disease or related dementias while enhancing the attractiveness of their communities to people of all ages; and

WHEREAS, AARP administers a national Network of Age-Friendly States and Communities as an affiliate to the World Health Organization Global Network for Age-friendly Cities and Communities program; and

WHEREAS, this program sets out eight (8) domains of community life that provide an effective framework for improving lives and enhancing communities, specifically: community and health services; outdoor spaces and buildings; transportation; housing; social participation; respect and social inclusion; civic participation and employment; and communication and information; and

WHEREAS, North Carolina residents have already enjoyed the success of the AARP Network of Age-Friendly States and Communities program in several cities, namely Archdale,

Durham, Jamestown, Matthews, Mount Airy; and counties, namely Buncombe, Durham, Forsyth, Lenoir, Mecklenburg, Orange, and Wake; and

WHEREAS, the State of North Carolina will become an age-friendly and dementia-friendly state through a renewed focus on the needs of the State's rapidly aging population and through cooperative efforts that foster livable communities and improve services and supports; and

WHEREAS, pursuant to Article III of the Constitution of North Carolina and N.C. Gen Stat. §§ 143A-4 and 143B-4, the Governor is the chief executive officer of the State and is responsible for formulating and administering the policies of the executive branch of state government; and

WHEREAS, pursuant to N.C. Gen. Stat. § 147-12, the Governor has the authority and duty to supervise the official conduct of all executive and ministerial officers.

NOW, THEREFORE, by the authority vested in me as Governor by the Constitution and the laws of the State of North Carolina, **IT IS ORDERED:**

Section 1. Multisector Plan for Aging

DHHS shall implement a planning process with expert working groups to develop a Multisector Plan for Aging in North Carolina. The planning process shall be led by the DHHS Division of Aging and Adult Services and the Division of Health Benefits and shall consist of representatives from state agencies and partner organizations including Hometown Strong, AARP NC, the NC Coalition on Aging, the Governor's Advisory Council on Aging, and other stakeholders and experts as identified by DHHS. The Multisector Plan for Aging will serve as a blueprint for the development, enhancement, and coordination of critical services for North Carolina's rapidly aging population, which will ultimately have positive impacts on individuals of all ages and abilities.

The Multisector Plan for Aging development process will include building an inventory of existing programs and services to identify efficient and effective practices in supporting healthy aging, as well as recommendations for scaling and extending these practices. The Multisector Plan for Aging will include key data indicators with 10-year targets.

A report on the Multisector Plan for Aging shall be submitted to the Office of the Governor no later than one (1) year from the date of this Executive Order. The Governor's Advisory Council on Aging will periodically review the Multisector Plan for Aging in North Carolina and make annual recommendations that support its goals.

Section 2. Caregiving Workforce Strategic Leadership Group

DHHS and the North Carolina Department of Commerce shall convene a Caregiving Workforce Strategic Leadership group with representatives from across education, workforce, and economic development. The Caregiving Workforce Strategic Leadership group will develop and implement recommendations to better recruit and retain workers in the areas of behavioral health, direct care, and nursing which will support North Carolina's aging population.

Section 3. Protection of Vulnerable Adults

DHHS shall collaborate with the Governor's Advisory Council on Aging and other stakeholders to make recommendations to improve protection of vulnerable adults from maltreatment, as adult protective services cases have increased by nearly seventy percent (70%) in the last five (5) years. Recommendations shall include revisions to North Carolina's adult protective services statutes, which have not had a thorough review since enactment in 1975. Recommendations shall also address improving the quality of practice across the state to meet the diverse needs of adults who are subject to maltreatment and improving community stakeholder

education and engagement in preventing maltreatment. A report on recommendations shall be submitted to the Office of the Governor one (1) year from the date of this Executive Order.

Section 4. Summit on Nutrition Services for Older Adults

DHHS shall collaborate with the Governor's Advisory Council on Aging to convene a summit to study and make recommendations regarding nutrition services available to older adults statewide and improvements needed to reduce food insecurity, which helps prevent further declines in health conditions among people who are aging.

Section 5. Improving Access to Outdoor Spaces for Older Adults

The North Carolina Department of Natural and Cultural Resources (DNCR) shall improve and promote outdoor spaces and buildings for use by older adults through outdoor recreation programming, with an emphasis on fourteen (14) Trail Day events during the 2023 NC Year of the Trail.

Section 6. Transportation for Older Adults

The North Carolina Department of Transportation (DOT) shall build upon its success in offering public transportation coverage across the state by implementing additional projects that improve the coverage, quality, reliability, and convenience of public transportation, including expansion of passenger rail services and improved first and last mile connections to fixed route rail and bus services.

DOT shall increase the convenience and flexibility of public transit by expanding on-demand micro-transit services and developing a statewide Mobility-as-a-Service system that allows for seamless trip planning, scheduling, and payment across services, modes, and jurisdictions.

DOT shall pursue additional deployments, testing and analysis of shared autonomous mobility technologies under the Connected Autonomous Shuttle Supporting Innovation (CASSI) program to determine the viability of shared autonomous vehicles as a safe and convenient alternative mode of transit for aging adults.

DOT, in coordination with metropolitan planning organizations, rural planning organizations, and local governments, shall collaborate to create safe, sustainable, and connected communities with diverse transportation options that benefit older adults and vulnerable road users.

Section 7. Broadband Access and Digital Literacy Services for Older Adults

The North Carolina Department of Information Technology (DIT) shall improve communication and outreach to the state's aging and older adult population as part of its continuing work to expand broadband access to ninety-eight percent (98%) of all North Carolina communities and raise high-speed internet subscriptions to eighty percent (80%) by 2026 as identified in the Governor's plan to close the digital divide.

DIT shall solicit feedback from older adults about their needs for high-speed internet access, digital devices, and digital literacy resources in the state's planning process to inform five-year comprehensive broadband and digital equity plans, including listening sessions with older adults and the community organizations that support them. DIT shall collaborate with staff at the DHHS Division of Aging and Adult Services to inform their work. DIT shall also form partnerships with organizations that serve aging adults to ensure this population benefits from ongoing DIT broadband infrastructure investments, promotion of the Affordable Connectivity Program to assist with internet service affordability, and support of digital navigation services to increase digital literacy.

DIT's Office of Digital Equity and Literacy shall partner with DHHS, Hometown Strong, the North Carolina Business Committee for Education and other state government agencies to identify specific strategies for raising digital awareness and digital literacy skill levels among the state's aging and older adult population.

DIT's Office of Digital Equity and Literacy, DNCR, DHHS, Hometown Strong, and the North Carolina Business Committee for Education shall promote digital literacy programs that support older adults including digital navigators and intergenerational coaching in order to improve access to telehealth and mental health supports.

Section 8. North Carolina's Application to Become Age-Friendly State

The State of North Carolina shall apply to become a member of the AARP Network of Age-Friendly States and Communities. Membership in this Network will provide access to AARP staff and volunteers who engage and mobilize communities, share expertise, and deliver technical assistance and access to other members to share experiences and best practices in creating age-friendly communities, as well as access to grant opportunities that assist in implementing age-friendly projects.

Section 9. Additional Cabinet Agency Work to Support Older Adults

Cabinet agencies are directed to cooperate in the implementation of this Executive Order. The activities directed by this Executive Order are not exhaustive of all state cabinet agency age-friendly planning efforts and programs and additional priorities will be identified by the development of the Multisector Plan for Aging.

Section 10. Other State Agencies

Council of State agencies, higher education institutions, local governments, private businesses, and other North Carolina entities are encouraged to support and provide input on the creation of age-friendly programs developed through the implementation of this Executive Order.

Section 12. Effect and Duration

This Executive Order is effective immediately and shall remain in effect until rescinded or superseded by another applicable Executive Order.

IN WITNESS WHEREOF, I have hereunto signed my name and affixed the Great Seal of the State of North Carolina at the Capitol in the City of Raleigh, this the 2nd day of May in the year of our Lord two thousand twenty-three.

Roy Cooper
Governor

ATTEST:

Rodney S. Maddox
Chief Deputy Secretary of State

I. SUBJECT MATTER EXPERT DISCUSSION QUESTIONS

1. The following questions were asked in an effort to seek insight from subject matter experts, such as Area Agency on Aging staff and Senior Center directors:

    i. From the list of services, identify the top 3 services in most demand in your region based on local community needs?

    ii. What are some of the key reasons for high waitlists and ideas for ways to combat the waitlists?

    iii. Identify 1-3 examples of programs you may have initiated to reach people of all ages/abilities in a more effective way?

    iv. What are the top 3 needs in your region that you would like to see addressed that will assist older adults and/or person with disabilities to continue to live independently?

    v. What would improve the quality of life within your community for older adults?

    vi. Give us some examples on what your agency is doing to address the social determinants of health?

    vii. How has technology enabled your region to achieve social connectedness?

    viii. What interventions have you utilized and found to be most effective in combating social isolation and loneliness among the aging population?

    ix. What are the major factors contributing to food insecurity in your region?

    x. What interventions and strategies have been successful in your region to increase enrollment in a nutrition program?

    xi. What is the biggest challenge in your region relating to housing for older adults?

    xii. How are transportation needs addressed in your community?

    xiii. What challenges do you see the State Aging Network Facing in the next 4 years?

J. LISTENING SESSION DATA

Location	Topic	Topic	Topic	Topic	Topic
Wilmington	Affordable Housing	Transportation/ Mobility	Caregiver Support	Access to Information and Services	Funding
Sylva	Affordable Housing	Transportation/ Mobility	Caregiver Support	Digital Gap/ Technology Access	Mental Health/ Social Isolation & Substance Abuse
Kernersville	Affordable Housing & Home Assistance	Caregiver and LTC Support	Transportation/ Mobility	Digital Gap/ Technology Access	Nutrition: Food Insecurity
Lumberton	Affordable Housing and Housing Assistance	Transportation/ Mobility	Social Isolation and Social Engagement	Caregiver Support	Access to Information & Expansion for Funding of Programs (ex. SCEP)
Greenville	Affordable Housing	Caregiver and LTC Support	APS Support (standardized services & trainings)	Transportation/ Mobility	Access to Information/ Services (Prevention focus)
Charlotte	Social Isolation and Social Engagement	Food Insecurity	Affordability and Sustainability of Services	Transportation/ Mobility	Caregiver and LTC Support

NCDHHS, Division of Aging and Adult Services State Aging Services Plan, Wilmington Listening Session 10/12/2022

Topic of Concern	Relevant Issues
Affordable Housing	▪ Affordable housing options throughout NHC and surrounding areas are limited, especially for the demographic of older adults. ▪ New housing developments are not perceived as supportive of the older population. Many are marketed toward younger adults. ▪ Existing and new housing is not considered affordable at average rates around $1,500.
Financial Concerns and Insurance	▪ Increasing federal minimum wage, which was last increased in 2009, would relieve the financial burden on working residents, particularly those considered low-income (at least $12/hour). ▪ Being in the "gap" offers no resources/support – many do not qualify for Medicaid and cannot afford placement or in-home care. ▪ Insurance correlates directly to quality of care.
Caregiver Support	▪ Although many caregiver support options exist across the country and abroad, gaps in exposure to these resources were identified. ▪ Individuals who could benefit from such services may lack awareness to them.

Healthcare	• Insufficient wait-time for medical appointments (1-3 hours). • Inconsistent medical patient referrals. • Access to quality care & services within the community. • Long distance travel, more than 3 hours (UNC / Duke), for healthcare specialist visits. • Wait-list for healthcare specialists. • Medical care quality is unfortunately based on ability to pay/insurance directly correlates to quality of care.
Political Information	• Access to information on candidate agendas relevant to older adult initiatives. • Empowering older adults to engage in voting rights.
Transportation	• Rural areas of concern ex. large land coverage within areas such as Brunswick County disperse services and residents. • Versatility in equitable transportation options for areas that include various barriers. • Innovative ideas for feasible modes of transportation • Reliable arrival/departure time for transportation services to necessary healthcare appointments.
Access to Information and Service Delivery	• Although NH County and Cape Fear regions offer many resources for 50+ communities, access and navigation to these resources need to be promoted through the age-friendly network domains. • Digital literacy and digital technology support is needed. • Integration of diversity, equity, and inclusion needs to be in the state and regional plans to prepare for the in-migration of retirees. • Programs/services offered in different communities (ex. Faith-based centers, work/ employment, disability centers, 55+ housing complexes etc.)

NCDHHS, Division of Aging and Adult Services State Aging Services Plan, Sylva Listening Session 10/21/22

Topic of Concern	Relevant Issues
Affordable Housing	• Existing and new housing is not considered affordable; cost of renting is high. • Housing application fees can add up and are expensive – people are on fixed incomes. • Many are one step away from homelessness. • Long wait lists to receive appropriate housing (leads to homelessness or having to jump from living from motels/hotels to another). • Increased number of Airbnb's in the community, but that does not help low-income older adults. • Instability of housing is stressful for anyone, but particularly for older single women (belongings are often in storage). • Cluster homes may be helpful in NC like Florida. • Many calls are related to housing repair/improvement needs – housing repair is a huge issue in rural counties and people want to stay in their own homes if they could get the appropriate housing repairs. • Calls for housing go unanswered. • People want to age in their own homes and not go into long-term care facilities.

Mobility/ Transportation	• Uneven grounds, gravel roads, and steps/slopes present safety issues with walking around communities/neighborhoods. • Transportation in rural areas and mountain areas are more challenging to get to services (groceries, medical appointments etc.). • Lack of coordinated routes. • Age friendly community access should also focus on access for older adults and not just for young people.
Caregiver and In-home Aide Support	• In-home worker shortages – funding is needed to increase numbers. • Need to strengthen caregiving programs and expand senior companion programs. • If someone does not fit into a "bucket" for a defined service, they can't get the service > need some flexibility.
Digital Access/Technology: Education and Training + Internet Scams/Frauds	• Access to Internet is spotty. • Older adults do not understand how to use technology and cannot afford devices – there needs to be appropriate trainings and accessibility to resources. • There needs to be more intergenerational opportunities. • Information needs to go to Senior Centers/Churches and not just offered electronically. • Not everyone can get to a Library to access information. • Literacy: Need more programs on how to navigate scams/frauds/financial exploitations.
Mental Health and Substance Abuse	• Ageism as it relates to not addressing substance abuse treatment and mental health issues among older adults. • Mental Behavioral health: will not accept older adults if non-ambulatory or over certain age. • Nursing homes will not take people with mental health issues. • Increased number of mental health issues. • Need training and education on therapy for addictions.
Volunteerism and Advocacy Needs	• Important to build STHL participation. • Need to re-build volunteerism in community and advocacy efforts for older adults.

NCDHHS, Division of Aging and Adult Services State Aging Services Plan, PTRC Listening Session 10/25/2022

Topic of Concern	Relevant Issues
Affordable Housing and Home Repairs	• The lack of affordable senior housing is reaching a crisis point. • Two senior housing communities in Kernersville all have waiting lists. One is 4 years long. • Need to acknowledge that wait list does not consider individuals who drop off the waiting list and never receive services. • Seniors are receiving a notice of a rent increase 45 days in advance, even if they are unable to afford the increase, they have no other alternative because of lengthy waiting lists at other locations. • Consider high density housing, not only subsidized or income-based, but affordable for everyone. • Need for rental assistance, age friendly housing and home repairs. • Seniors living in mobile homes are not eligible for programs to assist with home repairs because they do not own the land that they live on. • Adult and Family Care Homes need increased oversight. Requirement that CACs visit annually in family care homes is not adequate. Facilities need more visits.

Caregiver and In-Home Aide Support: Standards, Ratios and Funding	• The In-Home Service standards have not been revised since 1992. Recommends creating an entirely new Policy and Procedure manual in line with the current rules governing licensure that is user-friendly and with clear instructions and specific language to limit misunderstandings. • New P&P Manual should address the following: – How to rate functional impairments. – How to rate clients receiving services from unpaid caregivers. – Determining clients who are at high risk of long-term care placement. – Excluding clients with private pay services already in place. – How to assist clients who have been denied services because of pest infestations who are unable to afford pest control services. • Continue support and resources for caregivers, both respite and financial assistance. • Support inclusion in caregiver module; establishment of state caregiver strategy to provide recommendations to stakeholders; caregivers should include feedback on policies. • County recently lost funding for caregiver support services. • Need to increase services and resources for caregivers. • Need to increase funding for respite care. • A large number of caregiver recipients make too much for Medicaid but not enough to get help with in-home services; need higher income eligibility for Medicaid and in-home services. • Need to Create a statewide task force on Caregiving – make recommendations for a statewide strategy to meet the needs of caregivers, make sure caregivers are included in the task force. • Need to address the issue with individuals moving into LTC because they make too much to qualify for Medicaid to receive Services and supports at home. Many caregivers are able to help and want to keep their loved ones at home, but there are no services available. • LTC Ombudsmen - Recommendation is to have 1 Ombudsman for every 2000 beds in LTC facilities. NC should have 45 full time Ombudsmen and we currently have 33. Need to increase funding for the LTC Ombudsman Program. • Need increased funding for LTC Ombudsman Program. Cases have become more complex and time consuming, particularly since COVID. Need to have adequate funding to best serve residents. • Staffing Ratios in Long-Term Care - Nursing Homes are only required to have a nurse on staff for 40 hours a week. There is no specific staff to resident ratio for direct care staff. • No legislation on CNAs – need to set that ratio but need better pay and more CNA employees.
Food Insecurity	• During the pandemic agencies received an increase in funding for home delivered meals. When funding is eliminated, agencies will need to continue services as the need is there. NC is 4th in the US in Food Insecurity. • Farmers Market Program - need to better train vendors about the program, why are coupons not provided until July? Farmers market is open all year.
Transportation/Mobility	• Concrete seats and lack of ramps make it difficult for older people and people with mobility impairments to get up the stairs. • There is an issue with limited transportation and providers in rural areas.

Digital Gap/Technology Access and Social Isolation	• Social Isolation has major impacts for older adults' health, particularly in rural areas. Utilizing technology to connect older adults to family, friends and medical providers can help address the issue. Need to ensure that everyone in rural areas has adequate broadband/internet coverage as this is not the case currently. Need to make sure that internet is affordable as well as available. • Social Isolation - Many older individuals deteriorated during the pandemic due to isolation from family and friends. • Utilizing technology for doctors' visits is "demoralizing," Zoom meetings are ineffective. Older adults do not know how to use technology and it is not affordable for all. Seniors are being forced into something that they are not comfortable with and not capable of. • It is important to develop programs to connect older and younger generations. Look at what generations can give to each other- companionship, sharing of knowledge. Tap into civic groups and sororities to find people interested in serving in this capacity. • Our state faces a lack of significant connectivity for electronic devices (spotty internet). • Need to increase broadband coverage to allow older adults to participate in online classes, connect with friends/family, visit physicians virtually, and order groceries to be delivered.
Senior Center Funding	• Senior Center general purpose funding has not increased since 2004; Need additional $2.5M statewide for administrative costs for Senior Centers. • The required match for Senior Center General Purpose funding is too high and burdensome to centers. Match should be lowered to 10% in line with HCCBG programs or to none. • Senior Center Operations - no increase in funds since 2002. Population has doubled during this time. • Need to develop outcome and ROI measures for HCCBG services to benefit aging network and aging advocates (Solid data will help better allocate funding for services).

NCDHHS, Division of Aging and Adult Services State Aging Services Plan, Lumberton Listening Session 11/1/2022

Topic of Concern	Relevant Issues
Affordable Housing and Housing Assistance	• Cost is a huge issue (the cost of materials have increased).
Transportation	• Medical appointments take up the entire day because you have to leave at 5am and do not come back home until after 3pm. This is why appointments have higher no show rates. • Many people want to get involved in programs/events, but are unable to drive so a central van is needed.
Social Isolation and Social Engagement Through Senior Games	• There is need to market Senior Games better so that everyone can experience the different opportunities and benefit from the fellowship/connections.
SCEP Funding/Partnership	• Need additional funding for SCEP program to increase people's skills, confidence, prevent isolation, and enhance motivation; the funding currently only helps a few people in the county and enrollment is filled up quick.
Nutrition	• People are often picking between their bills or healthy groceries.

Digital Divide & Access to Information	• Before hospital discharges, there is a need for resource number(s) or resource guides. • Need to provide more information at Churches. • Devices need to be provided with the training to address digital divide.
Caregiving Support/ Respite Care	• Adult day centers are not affordable.

NCDHHS, Division of Aging and Adult Services State Aging Services Plan, Greenville Listening Session 11/3/2022

Topic of Concern	Relevant Issues
Prevention	• There needs to be more promotion of statewide activities to keep the brain active. • Increased promotion of the benefits of Senior Games. • Adopt community supported agriculture produce boxes with HCCBG funding. • Prevention - research (research based information needs to be better communicated to the public/community).
Coordination and Accessibility of Resources, Education, Training, and Services	• Need more ongoing, streamlined support to align support directly to needs/goals • Need to redesign program processes to better align services. • There is only one Adult Day Care Center in Region Q – unable to expand due to restrictions. • Insurance companies need to be more aware of community services. • STHL is the most powerful way to get people involved so we need to educate people about what STHL does. • It is important to reframe aging. • Need an awareness campaign because caregivers/older adults often do not call until their conditions or issues are not manageable and by then, their needs exceed the scope of care. • Need to look at waitlists.
Transportation	• More focus on bikeways, roads, crosswalks, and age-friendly neighborhoods; more collaboration with DOT. • Difficult to get around with region being so large and predominantly rural. • Specialty care is further away; Greenville is the hub, but other areas have challenges. • Many people want to be active, but have nowhere safe to go.
LTC Support and Caregiver Support	• The cap needs to be revised on respite care and who can be a caregiver (which eliminates immediate relatives/family). • Dementia-friendly trainings need to be embedded in CNA trainings. • Need to help build work force. • Increased awareness about "Grandparents raising grandchildren".
Housing	• Lack of affordable housing. • HHI services – needs go beyond railings/ramps – people need A/C, heat, floors fixed, handicap showers etc. • Need tiny houses on wheels to help support people who need help.
Elder Justice and APS	• Need to have a central intake for screening and standardize the service across the state. • People need to be held accountable for what they have done even after the person is safe (safety and accountability is missing). • Need to make S.A.F.E program mandatory for law enforcement in training. • Law enforcement need to learn how to communicate with older adults.

NCDHHS, Division of Aging and Adult Services State Aging Services Plan, Charlotte Listening Session 11/7/2022

Topic of Concern	Relevant Issues
Social Isolation	• During COVID, more individuals have deteriorated due to social isolation, among other natural causes, so we need to continue pushing outreach and wellness focused efforts • Need to push Wellness/Prevention focused efforts • Need to push Senior Games in the State Plan (participation and volunteerism)
Food Insecurity and Inclusion of Medically Tailored and Culturally Inclusive Meals: **> need for funding to support innovative programs** **> need to update manuals to reflect new guidelines**	• Lack of governmental funding: national legislatures have approved some increases, but they are not enough to cover the program needs and costs for congregated meals and home delivered meals. • Outdated federal/state guidelines: NC Manual is dated 2003...some to 1998. • More support from the state is needed. • Dietary guidelines have shifted, and language/vocabulary have changed too. • Medically tailored meals need to be addressed. • Need to add innovative programs to deliver grocery that allows older adults to choose/ select different options for their needs (need funding to support this model). • Educate about funding that comes to county; share models to fairly and equitably allocate funding from Home Care Community Care Block Grant. • 70% increase in meal costs (budget has increased).
Affordability of Adult Day Care Homes	• Concern: nothing is affordable, and most people rely on Medicaid programs (assisted living $5000+). • Facilities are not full (70-80%): there are options, but they are just not affordable. • Disparity: many fall in the gap and are not qualifying. • Cost of living increase will make many not qualify for programs anymore (risk for discharge). • Intergenerational Day Center: "eager to age in place, but desire socialization with activities of daily living".
Sustainability and Funding Needs: Fundings will expire post state of emergency COVID Cliff)	• Plan should address sustainability plan for providing services to growing population. • Were granted creative and innovative models with CARES, ARPA etc., but it is coming to an end. Examples: medically-tailored meals pilot (32 individuals) – participant survey showed that they lost weight, diabetes was under control etc.. • Need to address waiting lists. • How come regions get waivers? • Senior Center Funding: increase spaces and programs offered.
Transportation Options	• Lack of transportation options/transit services that inhibit ability of getting involved in programs/services. • Public transportation does not show up, have to use Uber to come to services/programs.

K. NC STATE AGING PLAN 2023-2027 SURVEY

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Aging and Adult Services

NC State Aging Plan 2023-2027 Community Survey

Every 4 years, the Division of Aging & Adult Services develops the State Plan on Aging which outlines the services and programs for older adults. With input from the community, we hope to undertake extensive efforts to examine how services and program delivery systems can be improved so we can better meet the needs of North Carolina's aging population. By completing this survey and providing valuable input on community needs, priorities, and challenges, you play a key role in our planning process and informing the State Plan on Aging.

1. Thinking about your future needs, how would you rate your community as a place to live for people as they age? ***[SELECT ONLY ONE OPTION]***
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
   - ☐ Don't Know/Not Sure

2. What community activities do you participate in? ***[CHECK ALL THAT APPLY]***
   - ☐ Library
   - ☐ Parks and Recreations Dept. or neighborhood community center
   - ☐ Religious/Faith-based Affiliation (church/temple/mosque, etc.)
   - ☐ Indoor/outdoor recreational activities or Health Club/Gym
   - ☐ Golf Club/Golfing
   - ☐ Local Senior Center
   - ☐ Veterans Service Organization
   - ☐ YMCA/YWCA
   - ☐ Community committees/clubs/organizations, advocacy/political action group organizations or volunteering at an organization
   - ☐ Community events/activities/gatherings
   - ☐ Adult education classes and programs
   - ☐ Work/employment
   - ☐ Arts/Music
   - ☐ Homebound due to caregiver/guardian responsibilities
   - ☐ Would participate, but no transportation
   - ☐ None
   - ☐ Other: please specify _____

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Aging and Adult Services

NC State Aging Plan 2023-2027 Community Survey

3. Below is a list of services for older adults that are currently available. Please select an option for each service to show how much you know about each program: ***[MARK AN "X' IN ONE BOX ON EACH ROW]***

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

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Aging and Adult Services

NC State Aging Plan 2023-2027 Community Survey

4. Please rate the concerns listed below about your safety: ***[MARK AN "X' IN ONE BOX ON EACH ROW]***

Concerns	Extremely Concerned	Moderately Concerned	Somewhat Concerned	Slightly Concerned	Not at all Concerned
I fear my health is declining					
I fear of aging alone					
I am afraid of falling					
I am worried about the safety of my neighborhood					
I fear someone will take advantage of me					
I worry about the structure and safety of my home					
I fear for my physical safety					

5. What would make healthy aging in NC better or easier for you? ***[Check all that apply]***

- ☐ Public transportation: free public transportation to older adults, access to transit options for medical appointments, grocery trips/errands etc.
- ☐ Affordable & available senior housing: retirement homes and senior living communities, need for more and better elderly housing options
- ☐ Medical care: struggles with medical coverage, medical insurance, need for financial assistance for medical care, specialized care difficult to come by, need for better medical providers within proximity
- ☐ In-home care and assisted living: need for available and affordable services for those who wish to stay in their home as they age
- ☐ Recreation & engagement: activities for seniors – exercise, classes, lectures, social functions, fathering etc.
- ☐ Senior services: access to resources, convenience stores, pharmacies without having to travel/drive)
- ☐ Access to information: Need a central 'hub' for information, lacking resources and information on what's available, such as programs, community events/news/activities, scheduling; better internet access needed in some areas.
- ☐ Walkability: side walking and biking lanes, plowed and well-maintained sidewalks, wheel accessible sidewalks etc.
- ☐ Senior centers: community center, gathering place with activities
- ☐ Other: please specify _____

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Aging and Adult Services

NC State Aging Plan 2023-2027 Community Survey

6. Please rate the importance of the following concerns based on how much you think they affect you, as you age in the community: ***[MARK AN "X" IN ONE BOX ON EACH ROW]***

Concerns	Very Important	Somewhat Important	Not Important	Not Sure	Not Applicable
Access to healthcare					
Financial security					
Maintaining physical health					
Transportation: easy and affordable access to public transportation					
Having enough food to eat					
Respite care					
Support for caregivers					
Safety during emergencies					
Affordable and accessible housing					
Finding assisted living facilities or nursing home					
Having access to recreation and social engagement opportunities					
Access to information about long-term support services					
Availability of in-home, long-term support services					
Quality long-term care options					
Feeling safe in my own home and community					

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Aging and Adult Services

NC State Aging Plan 2023-2027 Community Survey

7. Please rate the need for the following services in your community: ***[MARK AN "X' IN ONE BOX ON EACH ROW]***

Concerns	Very Important	Somewhat Important	Not Important	Not Sure	Not Applicable
In-home health services (personal care, such as medication management and/or bathing etc.)					
Home Modification Support					
Transportation					
Help with household chores (grocery shopping, cooking, changing lightbulbs, minor repairs or cleaning)					
Food assistance (Senior Congregate Meals, Meals on Wheels, Food Pantry, etc.)					
Evidence-based programs (disease prevention and health promotion services)					
Senior Centers					
Adult Day Program					
Health Screenings					
Legal assistance					
Financial assistance					
Social activities					

8. If you were not able to access one or more of the needed services listed above, why not? ***[CHECK ALL THAT APPLY]***
   - ☐ Mobility/Transportation
   - ☐ Finances
   - ☐ Difficulty with technology
   - ☐ Not aware of service availability
   - ☐ On a waiting list
   - ☐ Difficulty accessing information: No one to help me/I do not know where to go
   - ☐ I am embarrassed to ask for help
   - ☐ Other: please specify _____

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Aging and Adult Services

NC State Aging Plan 2023-2027 Community Survey

9. How do you get information about community services/where do you go for help? ***[CHECK ALL THAT APPLY]***
   - ☐ Area Agencies on Aging (AAA)
   - ☐ Family/friends/word of mouth
   - ☐ Newspaper/newsletter/listservs
   - ☐ Library
   - ☐ Internet/Websites
   - ☐ AARP
   - ☐ Senior Center
   - ☐ Town Offices
   - ☐ Religious Organizations
   - ☐ Parks and Recreation
   - ☐ Senior Meals
   - ☐ Care Coordinator, Case Manager, or Caregiver
   - ☐ Doctors Office/medical facilities
   - ☐ Social Media
   - ☐ TV/Radio
   - ☐ Other: please specify _____

10. Are you aware of food assistance program? ***[CHECK ALL THAT APPLY]***
   - ☐ Yes, I receive congregate meals
   - ☐ Yes, I receive Meals on Wheels
   - ☐ Yes, I receive food from a community food pantry
   - ☐ Yes, I receive food from my church or religious organization
   - ☐ Yes, I receive food from a governmental sponsored supplemental food source
   - ☐ No, I receive food from family, friends and/or neighbors
   - ☐ No, I do not need it
   - ☐ No, I am unaware of food assistance programs
   - ☐ No, I do not know how or where to apply for assistance
   - ☐ No, I do not think I am eligible
   - ☐ Other: please specify _____

11. In the past 12 months, have you had to skip paying for a basic need because of financial concerns? ***[CHECK ALL THAT APPLY]***
   - ☐ No
   - ☐ Yes – unable to pay for medication and medical bills
   - ☐ Yes – unable to pay for food
   - ☐ Yes – unable to pay for utility bills and housing
   - ☐ Other: please specify _____

NC State Aging Plan 2023-2027 Community Survey

12. Are you currently receiving any Medicaid Health Plan services? ***[SELECT ONLY ONE OPTION]***
    - ☐ Yes
    - ☐ No

13. Do you know how to find out if you are eligible for Medicaid services? ***[SELECT ONLY ONE OPTION]***
    - ☐ Yes
    - ☐ No

14. Do you know what type of services are offered by Medicaid health plan? ***[SELECT ONLY ONE OPTION]***
    - ☐ Yes
    - ☐ No

15. If eligible would you ENROLL/apply for the services? ***[SELECT ONLY ONE OPTION]***
    - ☐ Yes
    - ☐ No

16. Do you provide caregiving support weekly for any of the following individuals? ***[CHECK ALL THAT APPLY]***
    - ☐ No
    - ☐ Yes: grandchildren under the age of 18
    - ☐ Yes: an older adult
    - ☐ Yes: person with disability
    - ☐ Other: please specify _____

17. What are your top needs as a caregiver? ***[CHECK ALL THAT APPLY]***
    - ☐ Respite
    - ☐ Transportation assistance
    - ☐ Information and referrals
    - ☐ Coordinated services
    - ☐ Support groups
    - ☐ Funding
    - ☐ Education about diagnosis and care requirements
    - ☐ Socializing opportunities
    - ☐ Not Applicable
    - ☐ Other: please specify _____

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Aging and Adult Services

NC State Aging Plan 2023-2027 Community Survey

18. What abilities, skills, talents, or gifts or contributions could you bring forward to help other people in your community? ***[CHECK ALL THAT APPLY]***
    - ☐ Professional skills
    - ☐ Social engagement
    - ☐ Volunteering
    - ☐ Providing transportation
    - ☐ Experience with health care/medical knowledge
    - ☐ Donations
    - ☐ Experience with arts
    - ☐ Educational assistance
    - ☐ Advocacy
    - ☐ Home maintenance
    - ☐ Physical fitness and outdoor recreation
    - ☐ Serving on board/committees
    - ☐ Working with children
    - ☐ Other: please specify _____

19. Do you… ***[SELECT ONLY ONE OPTION]***
    - ☐ Live Alone
    - ☐ Live with Others
    - ☐ Other, please specify _____

20. What type of residence do you live in? ***[SELECT ONLY ONE OPTION]***
    - ☐ Rental Apartment
    - ☐ Rental House or Condominium
    - ☐ Own House or Condominium
    - ☐ Residential Facility w/care
    - ☐ Shelter
    - ☐ Other, please specify _____

21. Are you now or have you ever been homeless? ***[SELECT ONLY ONE OPTION]***
    - ☐ Yes
    - ☐ No

NC State Aging Plan 2023-2027 Community Survey

22. Would you say that in general your health is… ***[SELECT ONLY ONE OPTION]***
    - ☐ Excellent
    - ☐ Very Good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
    - ☐ Don't Know/Not Sure

23. What is your Age? ***[SELECT ONLY ONE OPTION]***
    - ☐ Under 50
    - ☐ 50-59
    - ☐ 60-64
    - ☐ 65-74
    - ☐ 75-84
    - ☐ 85 or older
    - ☐ Prefer not to answer

24. What is your Sex? ***[SELECT ONLY ONE OPTION]***
    - ☐ Female
    - ☐ Male
    - ☐ Other, please specify _____
    - ☐ Prefer not to answer

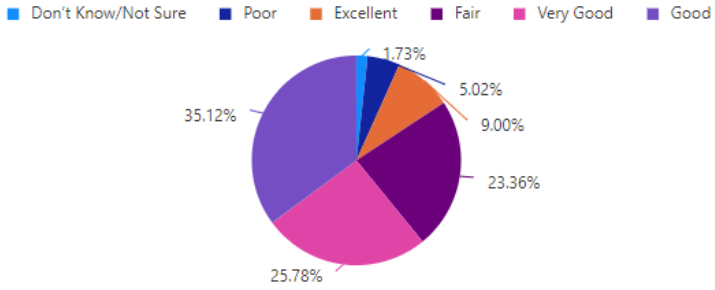
25. Which one best represents your Race/Ethnicity? ***[SELECT ONLY ONE OPTION]***
    - ☐ Asian/Asian American
    - ☐ Black/African American
    - ☐ Hispanic/Latino
    - ☐ Native American/Alaska Native
    - ☐ Native Hawaiian/Pacific Islander
    - ☐ White/Caucasian
    - ☐ Other, please specify _____
    - ☐ Prefer not to answer

26. What county do you live in? _____

L. NC STATE AGING PLAN 2023-2027 SURVEY ANALYSIS

1. Thinking about your future needs, how would you rate your community as a place to live for people as they age?

Option	Responses
Don't Know/Not Sure	10
Poor	29
Excellent	52
Fair	135
Very Good	149
Good	203



2. What community activities do you participate in? CHECK ALL THAT APPLY

Option	Responses
Religious/Faith-based Affilia...	344
Indoor/outdoor recreationa...	230
Parks and Recreations Dept....	273
YMCA/YWCA	69
Community events/activitie...	288
Work/employment	190
Arts/Music	203
Would participate, but no tr...	22
Library	281

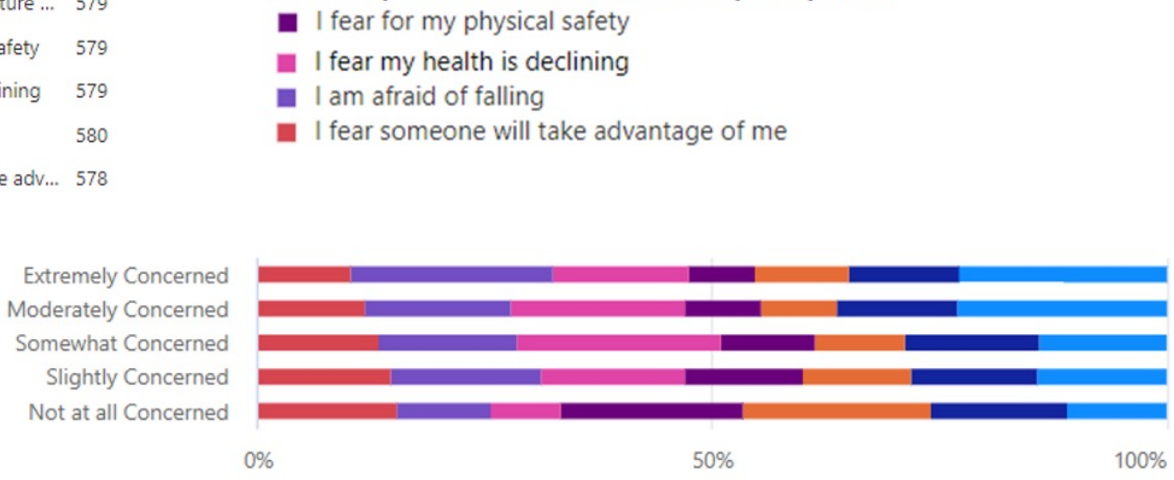
Option	Responses
Community committees/clu...	233
Adult education classes and...	155
Local Senior Center	254
Veterans Service Organizati...	36
Golf Club/Golfing	26
Homebound due to caregiv...	44
None	14
_Other	31

3. Below is a list of services for older adults that are currently available. Please select an option for each service to show how much you know about each program.

Option	Responses
Congregation Nutrition (me...	573
Care Management (assistan...	575
Home Delivered Meals (Me...	573
Adult Day Health Care (day ...	574
Senior Companion (volunte...	571
Institutional Respite Care (p...	571
Group Respite (provides car...	572
Housing and Home Improv...	573
Information and Case Assist...	573
Volunteer Program Develop...	571
Skilled Home (Health) Care ...	572
Health Promotion & Diseas...	574
Consumer-Directed Suppor...	572
Adult Day Care (day service...	577
Mental Health Counseling (...	572
Transportation (to medical ...	571
Health Screening (medical t...	575
In-Home Aide (help with pe...	573
Senior Center Operations (r...	573

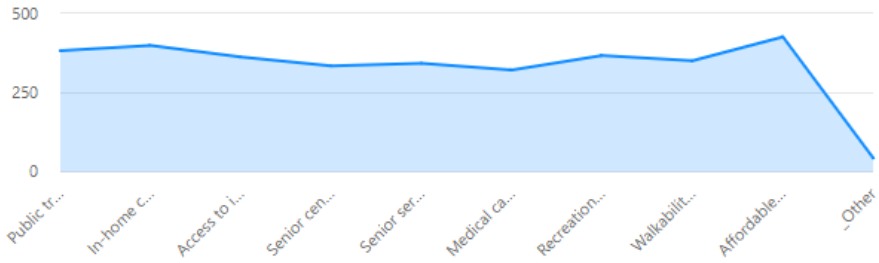
4. Please rate the concerns listed below about your safety.

Option	Responses
I fear of aging alone	576
I am worried about the safe...	578
I worry about the structure ...	579
I fear for my physical safety	579
I fear my health is declining	579
I am afraid of falling	580
I fear someone will take adv...	578



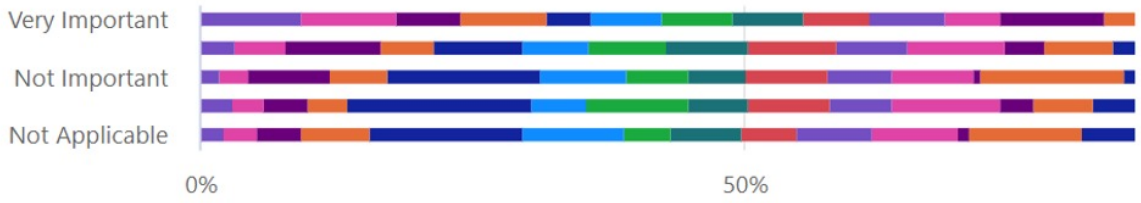
5. What would make healthy aging in NC better or easier for you? CHECK ALL THAT APPLY

Option	Responses
Public transportation: free p...	382
In-home care and assisted li...	399
Access to information: Nee...	362
Senior centers: community ...	334
Senior services: access to re...	342
Medical care: struggles with...	321
Recreation & engagement: ...	367
Walkability: side walking an...	350
Affordable & available seni...	426
_Other	42



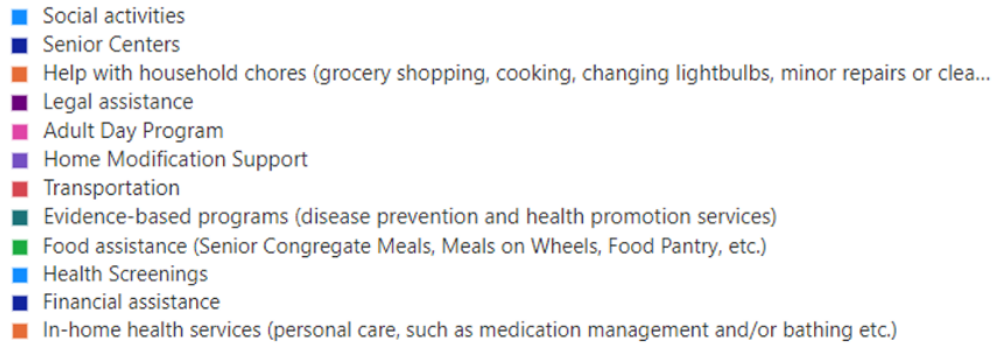
6. Please rate the importance of the following concerns based on how much you think they affect you, as you age in the community. the community.

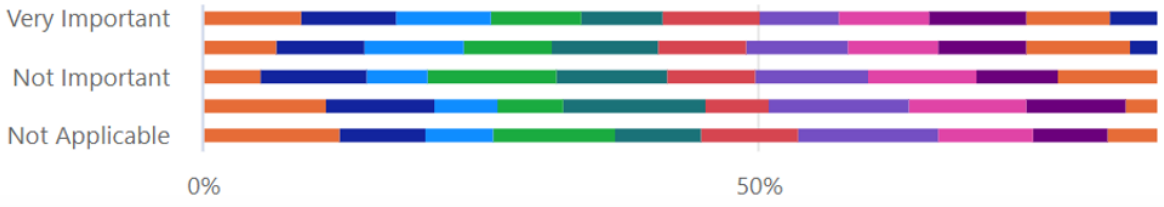
Option	Responses
Transportation: easy and aff...	576
Support for caregivers	574
Having enough food to eat	575
Maintaining physical health	579
Finding assisted living facilit...	574
Quality long-term care opti...	576
Access to information abou...	575
Availability of in-home, lon...	575
Safety during emergencies	574
Affordable and accessible h...	576
Respite care	573
Feeling safe in my own ho...	577
Having access to recreation...	576
Financial security	578
Access to healthcare	577



7. Please rate the need for the following services in your community.

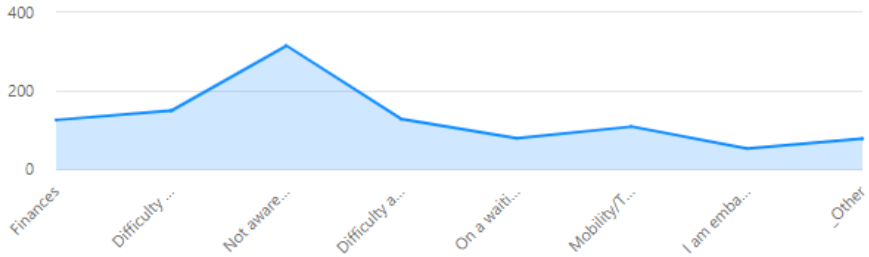
Option	Responses
Social activities	576
Senior Centers	576
Help with household chores...	573
Legal assistance	574
Adult Day Program	573
Home Modification Support	572
Transportation	574
Evidence-based programs (...	573
Food assistance (Senior Co...	573
Health Screenings	574
Financial assistance	572
In-home health services (pe...	575





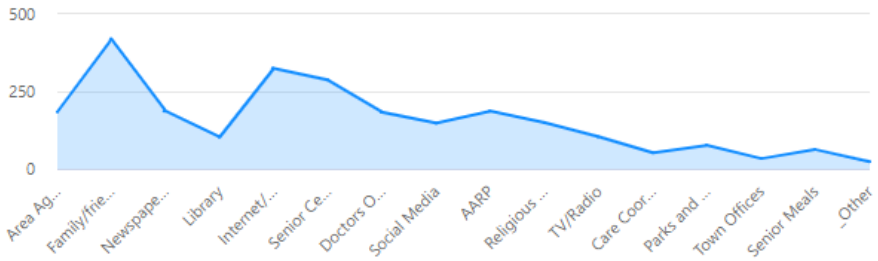
8. If you were not able to access one or more of the needed services listed above, why not? CHECK ALL THAT APPLY

Option	Responses
Finances	125
Difficulty with technology	149
Not aware of service availa...	315
Difficulty accessing informa...	127
On a waiting list	78
Mobility/Transportation	108
I am embarrassed to ask for...	52
_Other	77



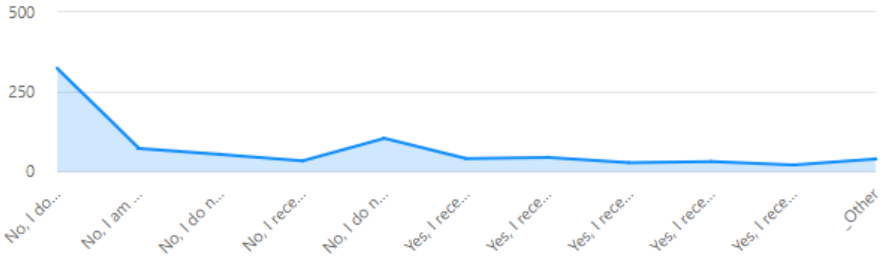
9. How do you get information about community services/where do you go for help? CHECK ALL THAT APPLY

Option	Responses
Area Agency on Aging (AAA)	184
Family/friends/word of mou...	419
Newspaper/newsletter/lists...	187
Library	103
Internet/Websites	325
Senior Center	287
Doctors Office/medical facil...	183
Social Media	148
AARP	186
Religious Organizations	149
TV/Radio	103
Care Coordinator, Case Ma...	52
Parks and Recreation	76
Town Offices	33
Senior Meals	62
_Other	23



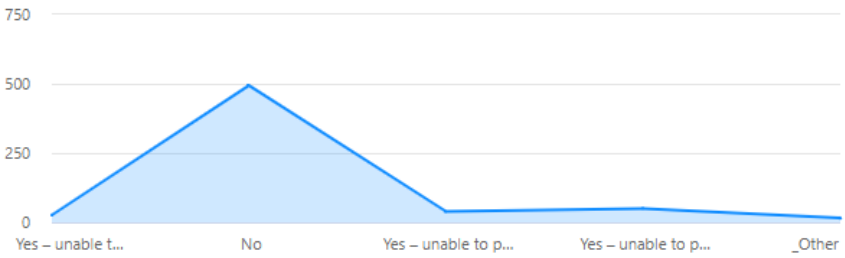
10. Are you aware of food assistance program? CHECK ALL THAT APPLY

Option	Responses
No, I do not need it	323
No, I am unaware of food a...	71
No, I do not know how or ...	52
No, I receive food from fa...	32
No, I do not think I am elig...	103
Yes, I receive congregate m...	39
Yes, I receive food from a c...	43
Yes, I receive food from my...	26
Yes, I receive food from a g...	30
Yes, I receive Meals on Wh...	19
_Other	38



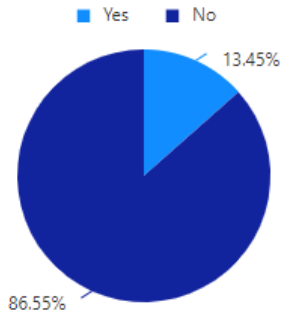
11. In the past 12 months, have you had to skip paying for a basic need because of financial concerns? CHECK ALL THAT APPLY

Option	Responses
Yes – unable to pay for food	26
No	494
Yes – unable to pay for utili...	39
Yes – unable to pay for me...	50
_Other	15



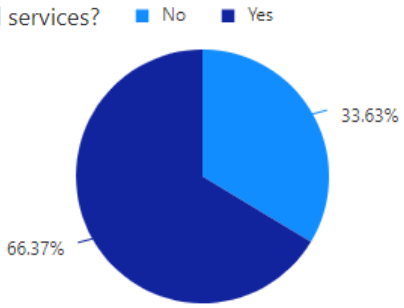
12. Are you currently receiving any Medicaid Health Plan services?

Option	Responses
Yes	76
No	489



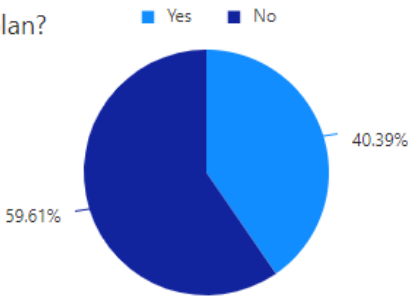
13. Do you know how to find out if you are eligible for Medicaid services?

Option	Responses
No	190
Yes	375



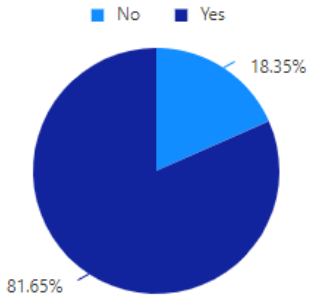
14. Do you know what type of services are offered by Medicaid health plan?

Option	Responses
Yes	225
No	332



15. If eligible would you ENROLL/apply for the services?

Option	Responses
No	100
Yes	445



16. Do you provide caregiving support weekly for any of the following individuals? CHECK ALL THAT APPLY

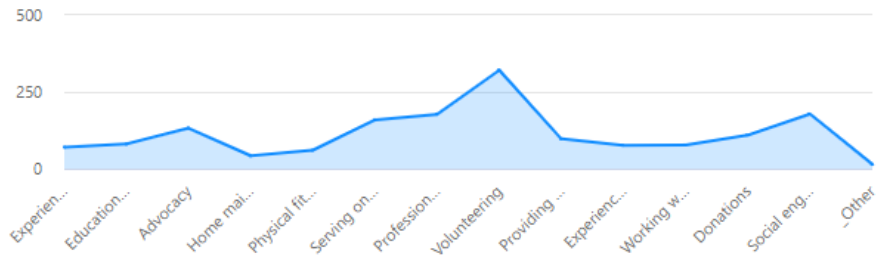
Option	Responses
Yes: an older adult	130
Yes: grandchildren under th...	44
Yes: person with disability	44
No	388
_Other	18

17. What are your top needs as a caregiver? CHECK ALL THAT APPLY

Option	Responses
Information and referrals	85
Coordinated services	91
Support groups	77
Education about diagnosis ...	57
Socializing opportunities	80
Funding	71
Respite	98
Transportation assistance	59
Not Applicable	284
_Other	13

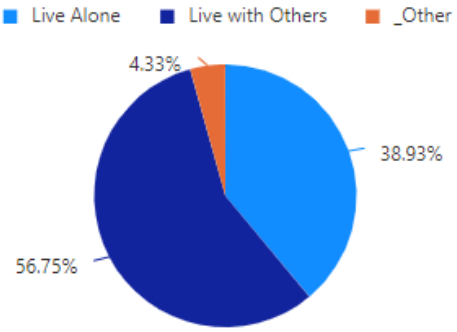
18. What abilities, skills, talents, or gifts or contributions could you bring forward to help other people in your community? CHECK ALL THAT APPLY

Option	Responses
Experience with arts	70
Educational assistance	80
Advocacy	132
Home maintenance	42
Physical fitness and outdoo...	60
Serving on board/committe...	159
Professional skills	177
Volunteering	321
Providing transportation	97
Experience with health care...	76
Working with children	77
Donations	109
Social engagement	178
_Other	14



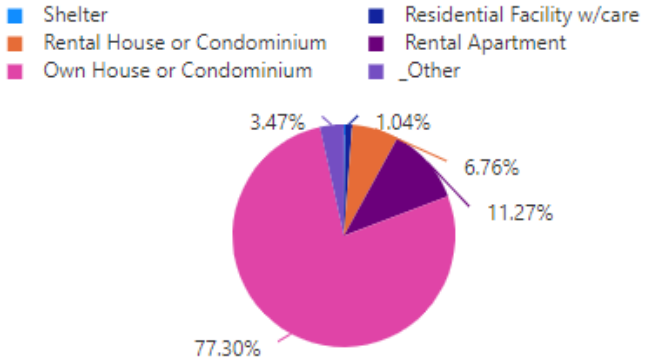
19. Do you...

Option	Responses
Live Alone	225
Live with Others	328
_Other	25



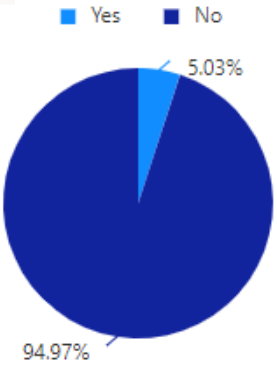
20. What type of residence do you live in?

Option	Responses
Shelter	1
Residential Facility w/care	6
Rental House or Condomin...	39
Rental Apartment	65
Own House or Condominiu...	446
_Other	20



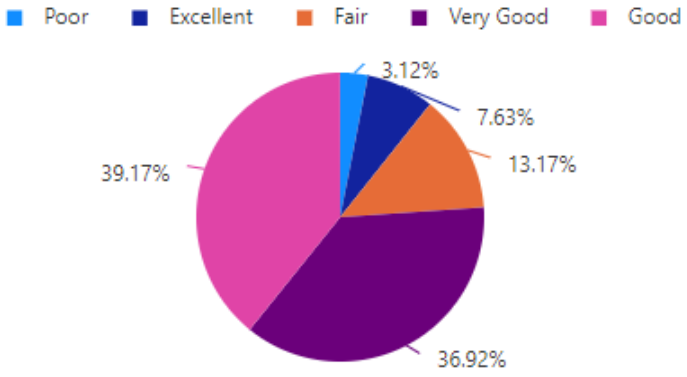
21. Are you now or have you ever been homeless?

Option	Responses
Yes	29
No	548



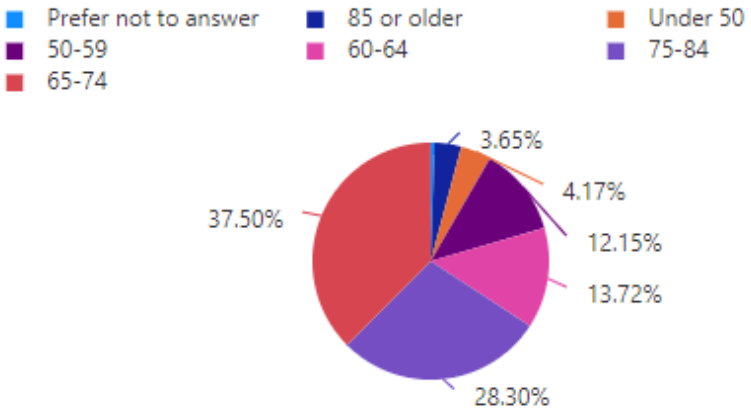
22. Would you say that in general your health is...

Option	Responses
Poor	18
Excellent	44
Fair	76
Very Good	213
Good	226



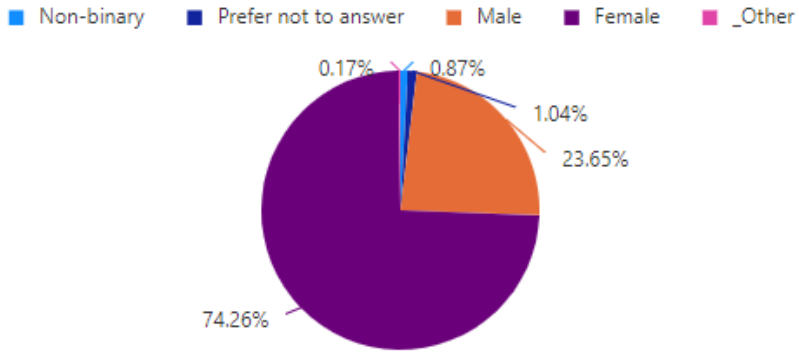
23. What is your Age?

Option	Responses
Prefer not to answer	3
85 or older	21
Under 50	24
50-59	70
60-64	79
75-84	163
65-74	216

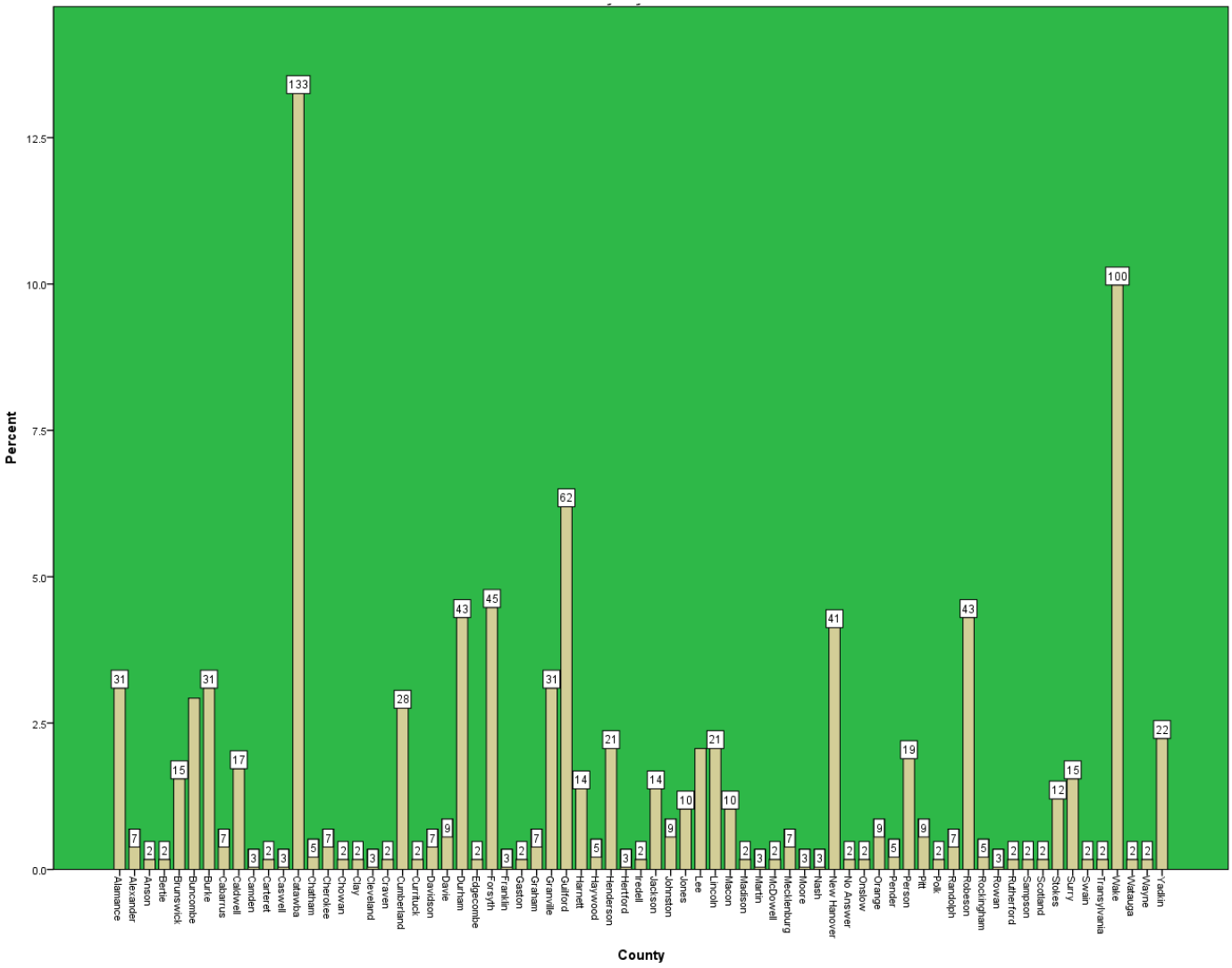


24. What is your Sex?

Option	Responses
Non-binary	5
Prefer not to answer	6
Male	136
Female	427
_Other	1



26. What county do you live in?



M. ADULT PROTECTIVE SERVICES DEMOGRAPHICS & OUTCOMES DATA

Adult Protective Services reports are consistently increasing each state fiscal year.

DEMOGRAPHICS AND OUTCOMES FOR ADULT PROTECTIVE SERVICES FY 2021-2022

Who are the Adults and Their Families?	What is Happening to Them?	What Do These Adults and Their Families Need?
▪ In FY 2021-2022 34,470 reports were received by County Departments of Social Services alleging abuse, neglect or exploitation of adults. ▪ 20,510 of the reports were screened-in for Adult Protective Services (APS) to determine whether the adults reported as being abused, neglected or exploited needed protective services. ▪ Older adults comprised the majority of those receiving APS; 76 percent were 60 or older, 24 percent were aged 18 – 59. ▪ Woman comprised 57 percent of the total reports screened-in, and men 43 percent. ▪ Seventy percent of the adults reported were white, 27 percent were black, one percent were Hispanic, and the remaining two percent were Native American, Asian and others. ▪ Many of the adults reported were living in our communities. Eighty-five percent lived alone or with family members, while 15 percent lived in a facility, institution or shelter.	▪ Abuse, neglect or exploitation was found for 8,446 (46 percent) of the reports screened-in. ▪ Neglect (87 percent) was the most common form of mistreatment found. Sixty-seven percent of the neglect situations involved self-neglect. Nineteen percent involved caretaker neglect. ▪ Abuse was found in three percent of the situations. ▪ Exploitation was found in 10 percent of the situations. ▪ When mistreatment was found, the most frequently named perpetrator was self-neglector, followed by an adult child, spouse, sibling and other. ▪ The most common disabilities experienced by mistreated adults were: – Physical illness ▪ Other physical impairments (not listed) – Alzheimer's Disease and related disorders – Mental illness	▪ Factors which may have contributed to the abuse, neglect or exploitation of adults living at home included: – Physical impairment – Mental/emotional impairment – Physically frail/dependent – Inadequate health care – Unsafe environment – Inadequate knowledge of health care needs – Substance misuse – Unstable living environment ▪ The primary factors identified as contributing to mistreatment in facilities included: – Inadequate supervision/ management – Inadequate knowledge/training of care needs ▪ The most frequently identified services needed to address the abuse, neglect or exploitation included: – Placement – Medical/Health care – In-home aide service – Legal/surrogate decision maker – Other – Mental health

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • GOVERNOR
KODY H. KINSLEY • SECRETARY
JOYCE MASSEY-SMITH, MPA •
DIRECTOR, DIVISION OF AGING AND ADULT SERVICES

Adult Services
SFY: 2020-2021
Final Report

Joyce Massey-Smith, Director
Karey Perez, Adult Services Section Chief
Sarah Richardson, Adult Services Program Administrator
Angie Phillips, Special Assistance Program Administrator

Table of Contents

Adult Protective Services (APS)

Adult Protective Services (APS) is a statutorily mandated service that provides for the protection of disabled and vulnerable adults. North Carolina General Statute 108A gives county departments of social services the authority to evaluate reports of abuse, neglect, and exploitation when a disabled adult is the alleged victim. The primary purpose of Adult Protective Services is to help the disabled adult who has experienced or is experiencing maltreatment to be free from abuse, neglect, and exploitation. The available funds to pay for these services are limited, often depleted early in the state fiscal year, and primarily funded by counties.

Adult Protective Services reports are consistently increasing each state fiscal year. North Carolina ranks 9th nationally in total population (10.6 million) and in the number of people 65 and older. In 2025, 1 in 5 North Carolinians will be 65 or older. Our 65 and older population will almost double in the next twenty years. Individuals 85 and older will be the fastest growing segment beginning 2030, when 2.4 million baby boomers approach their 85th birthday. NC State Aging Profile 2018

The data in this report was provided by each of the 100 county departments of social services and the Office of State Budget Management.

APS Reports Received in NC for SFY 2020-2021

Total: 32,075

County Name	Total	County Name	Total	County Name	Total
Alamance	651	Franklin	128	Pamlico	52
Alexander	164	Gaston	1139	Pasquotank	142
Alleghany	103	Gates	17	Pender	164
Anson	50	Graham	44	Perquimans	83
Ashe	159	Granville	110	Person	151
Avery	25	Greene	52	Pitt	728
Beaufort	252	Guildford	1091	Polk	129
Bertie	96	Halifax	128	Randolph	393
Bladen	134	Harnett	190	Richmond	171
Brunswick	382	Haywood	375	Robeson	669
Buncombe	1984	Henderson	586	Rockingham	594
Burke	381	Hertford	81	Rowan	368
Cabarrus	394	Hoke	139	Rutherford	402
Caldwell	390	Hyde	12	Sampson	195
Camden	13	Iredell	165	Scotland	57
Carteret	350	Jackson	210	Stanly	197
Caswell	61	Johnston	405	Stokes	196
Catawba	610	Jones	35	Surry	225
Chatham	164	Lee	144	Swain	99
Cherokee	192	Lenoir	177	Transylvania	244
Chowan	94	Lincoln	370	Tyrrell	11
Clay	55	Macon	160	Union	393
Cleveland	881	Madison	80	Vance	81
Columbus	166	Martin	94	Wake	1161
Craven	458	McDowell	155	Warren	22
Cumberland	1179	Mecklenburg	2715	Washington	73
Currituck	79	Mitchell	52	Watauga	124
Dare	56	Montgomery	148	Wayne	463
Davidson	419	Moore	513	Wilkes	397
Davie	82	Nash	228	Wilson	374
Duplin	206	New Hanover	1362	Yadkin	97
Durham	733	Northampton	32	Yancey	96
Edgecombe	187	Onslow	619		
Forsyth	355	Orange	263		

**Data collected through AS Monthly Survey*

APS Reports Screened In & Screened Out

Total Screened In Reports:	18,844	Total Screened Out Reports:	13,231

County Name	IN	OUT	%	County Name	IN	OUT	%	County Name	IN	OUT	%
Alamance	296	355	45%	Franklin	59	69	46%	Pamlico	17	35	33%
Alexander	90	74	55%	Gaston	859	280	75%	Pasquotank	72	70	51%
Alleghany	33	70	32%	Gates	10	7	59%	Pender	102	62	62%
Anson	27	23	54%	Graham	35	9	80%	Perquimans	37	46	46%
Ashe	69	90	43%	Granville	58	52	53%	Person	83	68	55%
Avery	16	9	64%	Greene	44	8	85%	Pitt	582	146	80%
Beaufort	228	24	90%	Guildford	648	443	59%	Polk	54	75	42%
Bertie	53	43	55%	Halifax	84	44	66%	Randolph	184	209	47%
Bladen	74	60	55%	Harnett	133	57	70%	Richmond	80	91	47%
Brunswick	200	182	52%	Haywood	235	140	63%	Robeson	565	104	84%
Buncombe	1391	593	70%	Henderson	319	267	54%	Rockingham	197	397	33%
Burke	314	67	82%	Hertford	50	31	62%	Rowan	142	226	39%
Cabarrus	223	171	57%	Hoke	115	24	83%	Rutherford	263	139	65%
Caldwell	231	159	59%	Hyde	8	4	67%	Sampson	161	34	83%
Camden	10	3	77%	Iredell	86	79	52%	Scotland	48	9	84%
Carteret	267	83	76%	Jackson	94	116	45%	Stanly	145	52	74%
Caswell	43	18	70%	Johnston	311	94	77%	Stokes	113	83	58%
Catawba	390	220	64%	Jones	23	12	66%	Surry	88	137	39%
Chatham	55	109	34%	Lee	72	72	50%	Swain	59	40	60%
Cherokee	101	91	53%	Lenoir	108	69	61%	Transylvania	124	120	51%
Chowan	39	55	41%	Lincoln	153	217	41%	Tyrrell	9	2	82%
Clay	35	20	64%	Macon	77	83	48%	Union	213	180	54%
Cleveland	209	672	24%	Madison	56	24	70%	Vance	54	27	67%
Columbus	105	61	63%	Martin	58	36	62%	Wake	754	407	65%
Craven	195	263	43%	McDowell	96	59	62%	Warren	18	4	82%
Cumberland	496	683	42%	Mecklenburg	1025	1690	38%	Washington	52	21	71%
Currituck	50	29	63%	Mitchell	27	25	52%	Watauga	65	59	52%
Dare	44	12	79%	Montgomery	85	63	57%	Wayne	296	167	64%
Davidson	259	160	62%	Moore	256	257	50%	Wilkes	294	103	74%
Davie	45	37	55%	Nash	107	121	47%	Wilson	336	38	90%
Duplin	185	21	90%	New Hanover	1052	310	77%	Yadkin	57	40	59%
Durham	411	322	56%	Northampton	22	10	69%	Yancey	63	33	66%
Edgecombe	80	107	43%	Onslow	499	120	81%				
Forsyth	235	120	66%	Orange	154	109	59%				

**Data collected through AS Monthly Survey*

APS, Information and Referral, and Outreach

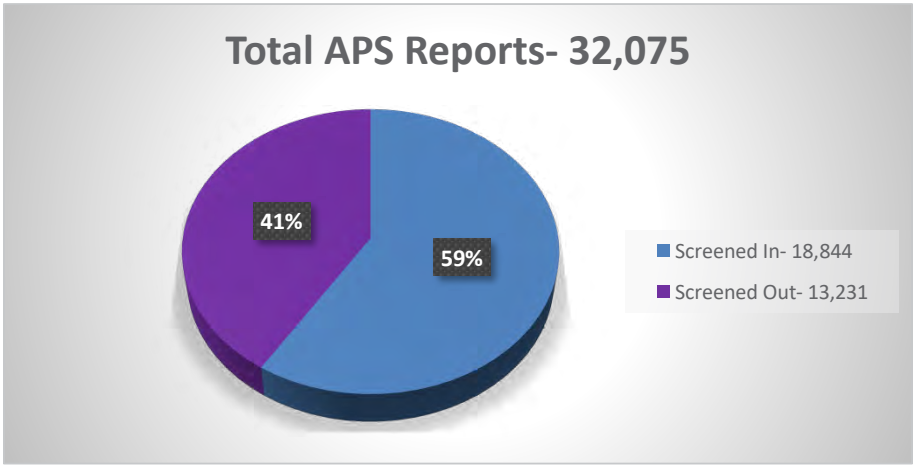
Adult Protective Services reports are received by county departments of social services. The information is reviewed to determine whether it meets the criteria mandated in N.C. General Statute 108A. The three criteria are:

1) a disabled adult

2) who has been abused, neglected or exploited, and

3) is in need of protective services.

If any of the three criteria are not met, the APS report is screened out. The individual may be provided information & referral or outreach. The information may be referred to another agency or given additional information about resources in the community. An outreach may be completed with the adult in their home or through a phone call to gather additional information and provide services or resources.



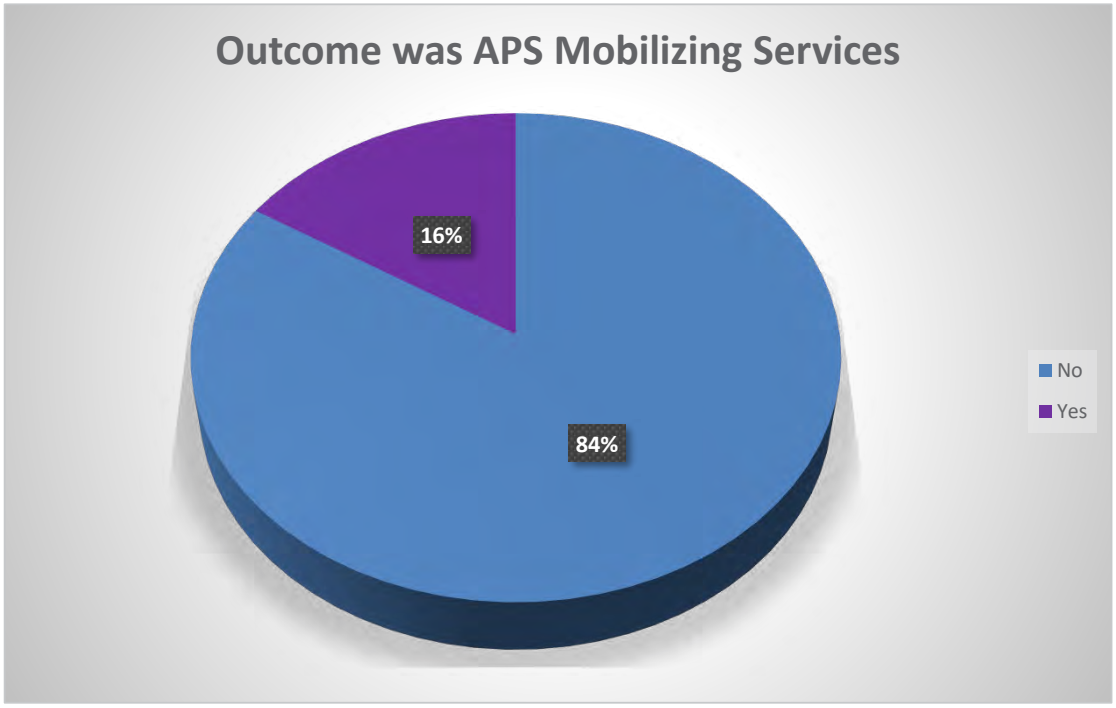
Counties Provided Information and Referral or Outreach for 20,770 individuals.

APS - Distinct Client Count

County Name	202	204	County Name	202	204	County Name	202	204
Alamance	400	179	Franklin	87	13	Pamlico	10	2
Alexander	73	15	Gaston	654	213	Pasquotank	52	2
Alleghany	33	10	Gates	15	5	Pender	96	32
Anson	26	6	Graham	44	8	Perquimans	15	2
Ashe	63	11	Granville	51	14	Person	75	18
Avery	22	1	Greene	34	5	Pitt	1233	94
Beaufort	192	36	Guildford	994	30	Polk	31	12
Bertie	64	9	Halifax	54	12	Randolph	110	7
Bladen	54	5	Harnett	139	14	Richmond	29	9
Brunswick	196	17	Haywood	185	26	Robeson	429	143
Buncombe	673	106	Henderson	235	31	Rockingham	100	52
Burke	240	21	Hertford	28	11	Rowan	104	15
Cabarrus	196	24	Hoke	103	15	Rutherford	156	3
Caldwell	280	37	Hyde	22	3	Sampson	157	38
Camden	24	1	Iredell	78	23	Scotland	40	13
Carteret	158	33	Jackson	70	12	Stanly	148	10
Caswell	100	6	Johnston	315	47	Stokes	48	9
Catawba	284	33	Jones	18	1	Surry	82	34
Chatham	54	11	Lee	63	1	Swain	50	15
Cherokee	86	17	Lenoir	85	6	Transylvania	68	12
Chowan	34	8	Lincoln	115	23	Tyrrell	5	4
Clay	27	6	Macon	68	8	Union	165	30
Cleveland	168	33	Madison	48	12	Vance	40	8
Columbus	63	12	Martin	59	3	Wake	716	99
Craven	115	62	McDowell	70	13	Warren	41	3
Cumberland	641	48	Mecklenburg	917	172	Washington	38	2
Currituck	50	2	Mitchell	22	5	Watauga	22	2
Dare	41	6	Montgomery	67	16	Wayne	198	29
Davidson	189	28	Moore	158	16	Wilkes	254	25
Davie	27	15	Nash	88	9	Wilson	289	40
Duplin	149	15	New Hanover	709	112	Yadkin	32	2
Durham	540	107	Northampton	21	4	Yancey	55	6
Edgecombe	110	21	Onslow	288	42			
Forsyth	234	21	Orange	363	22			

**Data collected through Client Services Data Warehouse*

APS - Reporting



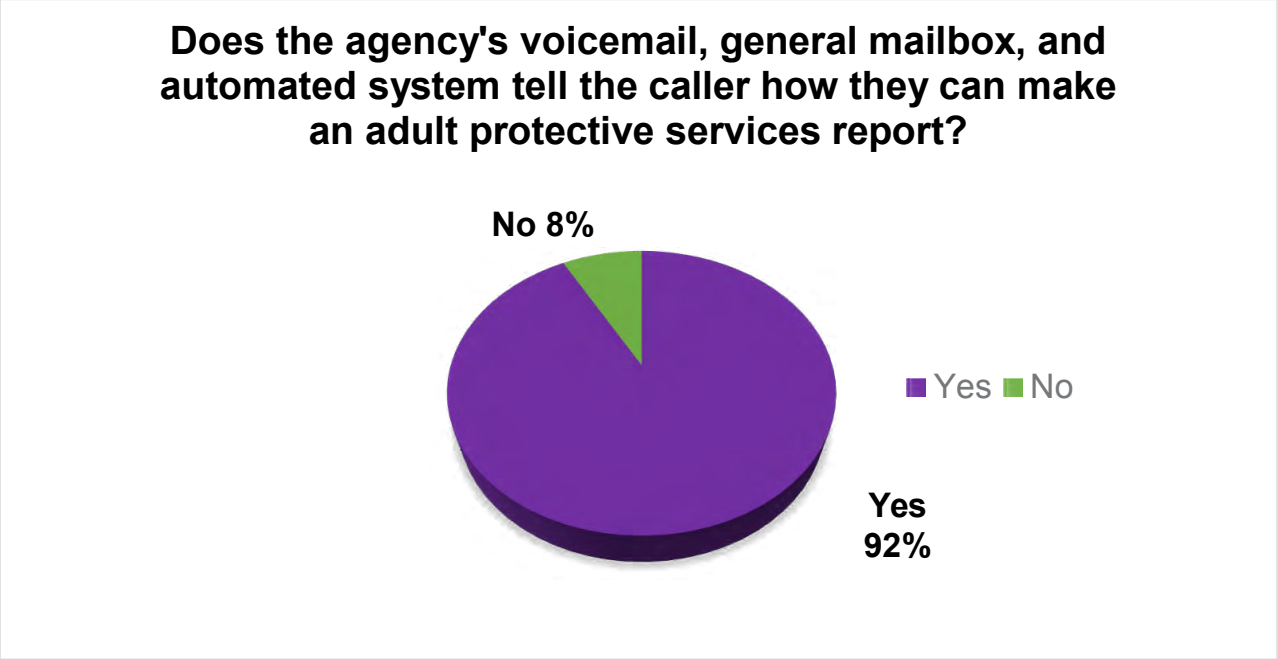
State totals for unduplicated 202 cases:

16,761

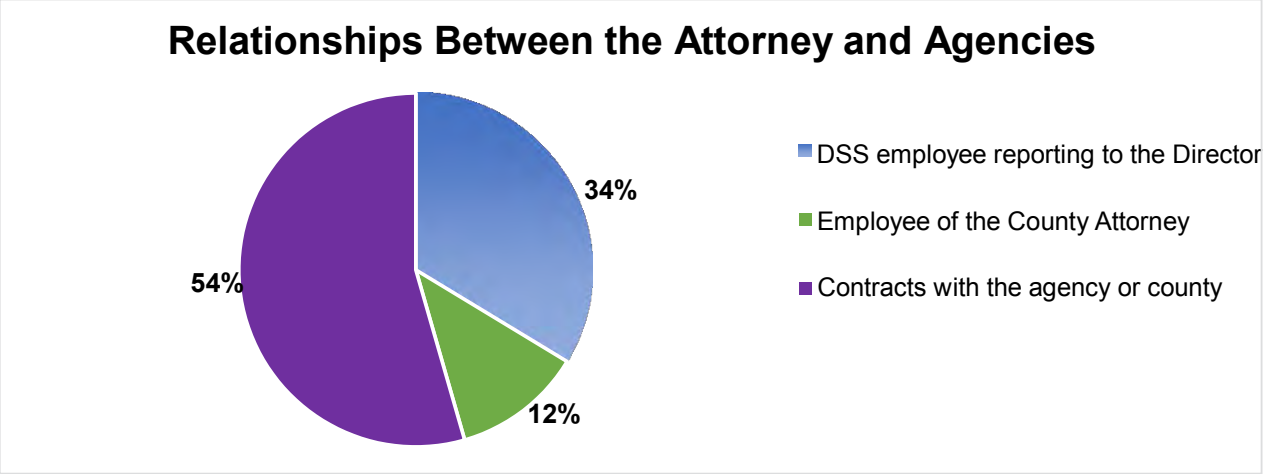
State totals for unduplicated 204 cases:

2,681

APS - Continuous Access



85% of County Agencies use an outside party for afterhours business calls. (i.e., Law Enforcement)



APS Average Statewide Caseload Information

The following data reflects the average number of Adult Protective Services report evaluations and the number of Mobilizing Adult Protective Services cases that county departments of social services staff were assigned, on average, per month in SFY 2020-2021.

The county departments of social services must complete a thorough evaluation of the disabled adult's need for protection. The county must complete reports of abuse or neglect within 30 days and within 45 days for exploitation.

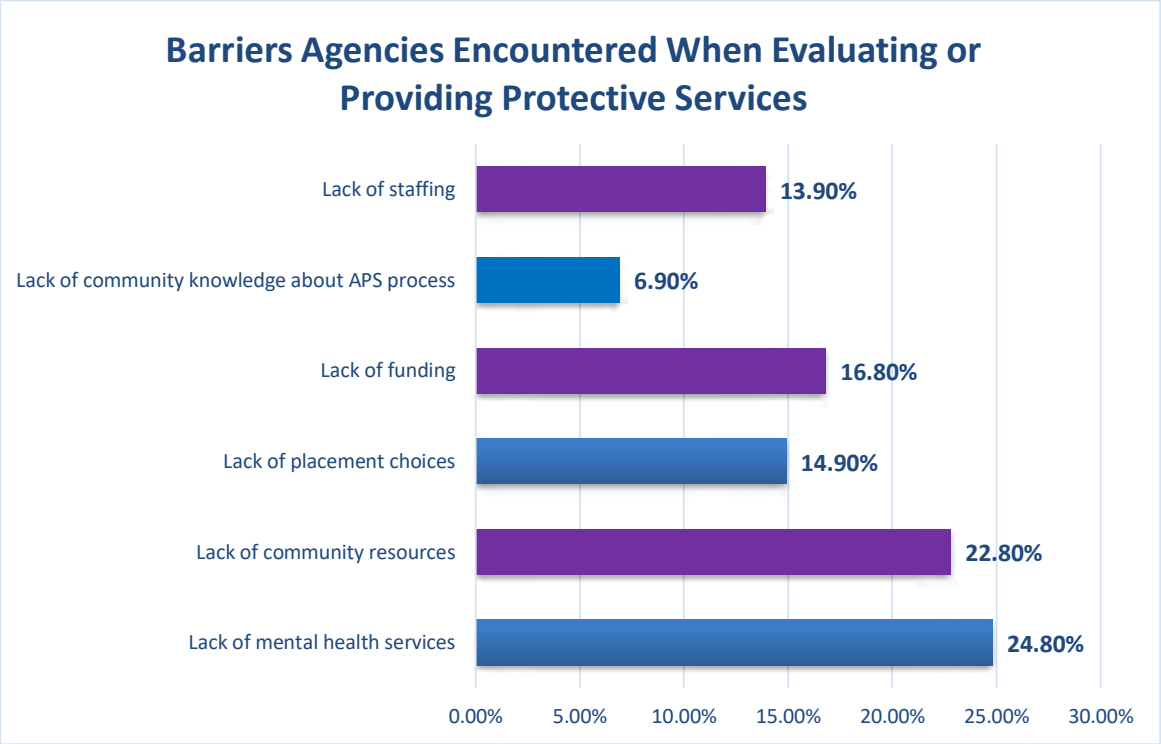
Mobilization of Adult Protective Services are provided when an Adult Protective Services evaluation has been completed, and abuse, neglect or exploitation has been confirmed and the need for protective services has been substantiated. Regular visits with the adult are made to ensure that services are put into place to prevent further maltreatment.

Average monthly caseload size for staff in SIS Code 202 (Evaluation)	**Average monthly caseload size for staff in SIS Code 204 (Mobilizing Services)**
4.82	2.06
Average # of weeks newly hired staff assumed a caseload:	3.2 Weeks

**Data collected through AS Annual Survey*

Barriers Encountered During the APS Process

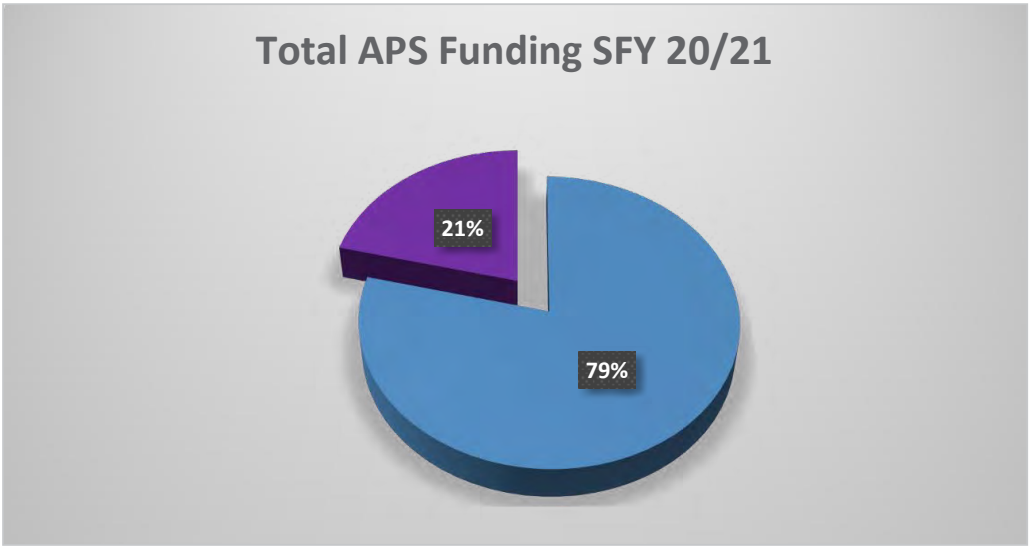
County departments of social services ranked the obstacles they experienced during the Adult Protective Services process. Lack of mental health services (24.8%) and Lack of Community Resources (22.8%) were top ranked for the leading Barriers for SFY 20/21. Below, the stacked bar graph demonstrates how the other obstacles ranked.



Adult Protective Services Funding

Adult Protective Services is federally funded through the Social Services Block Grant (SSBG), which is also the major source of funding for several other programs at county departments of social services. Funding is limited, and must be shared across several different areas, resulting in many counties using all their allocation by the midpoint of the state fiscal year. Once this funding is depleted, then county funds must cover the remaining cost of providing the statutorily mandated program. At the beginning of SFY 2021-2022, Medicaid Administrative Claiming (MAC) was opened up to APS as a funding source for counties. The impact of this much needed additional funding is already visible a few months into the fiscal year and continues to grow.

County	Federal-SSBG
$24,989,183.16	$6,683,410.97
79%	21%



Adult Protective Services Reports

SFY # of reports:	17,524	SFY monthly average of reports with prior intervention (INTV):	25.22

County Name	Total # of Reports	# with Prior APS INTV	County Name	Total # of Reports	# with Prior APS INTV	County Name	Total # of Reports	# with Prior APS INTV
Alamance	206	13	Franklin	66	9	Pamlico	12	1
Alexander	87	15	Gaston	849	162	Pasquotank	70	10
Alleghany	58	11	Gates	8	2	Pender	121	16
Anson	20	0	Graham	35	4	Perquimans	30	5
Ashe	59	8	Granville	60	5	Person	70	5
Avery	9	0	Greene	39	8	Pitt	427	50
Beaufort	243	41	Guildford	618	86	Polk	53	7
Bertie	47	5	Halifax	70	3	Randolph	156	20
Bladen	63	9	Harnett	127	11	Richmond	67	8
Brunswick	186	25	Haywood	205	30	Robeson	565	92
Buncombe	1089	203	Henderson	283	36	Rockingham	195	30
Burke	286	49	Hertford	47	6	Rowan	140	21
Cabarrus	223	33	Hoke	110	22	Rutherford	246	37
Caldwell	211	26	Hyde	9	0	Sampson	182	19
Camden	9	0	Iredell	81	2	Scotland	47	5
Carteret	257	40	Jackson	87	10	Stanly	137	17
Caswell	37	2	Johnston	311	41	Stokes	98	20
Catawba	368	56	Jones	18	0	Surry	79	5
Chatham	50	4	Lee	67	7	Swain	58	8
Cherokee	86	12	Lenoir	109	16	Transylvania	107	23
Chowan	37	6	Lincoln	153	22	Tyrrell	6	0
Clay	32	4	Macon	56	7	Union	222	30
Cleveland	193	29	Madison	61	7	Vance	44	5
Columbus	88	12	Martin	58	6	Wake	756	98
Craven	119	17	McDowell	100	21	Warren	25	2
Cumberland	616	101	Mecklenburg	987	131	Washington	54	3
Currituck	64	12	Mitchell	23	4	Watauga	20	2
Dare	44	4	Montgomery	82	13	Wayne	279	32
Davidson	244	28	Moore	245	38	Wilkes	301	52
Davie	39	6	Nash	94	7	Wilson	282	38
Duplin	165	22	New Hanover	1022	197	Yadkin	52	5
Durham	382	54	Northampton	18	0	Yancey	63	10
Edgecombe	86	7	Onslow	415	77			
Forsyth	211	16	Orange	133	19			

** APS-R Charts are based on the APS 702-1 report with a run date of 07-01-2021.*

Substantiation and Confirmation Rates

SFY Average Confirmation Rate:	47%	SFY Average Substantiation Rate:	24%

County Name	Confirm. Rate	Sub. Rate	County Name	Confirm. Rate	Sub. Rate	County Name	Confirm. Rate	Sub. Rate
Alamance	61%	43%	Franklin	48%	19%	Pamlico	33%	16%
Alexander	48%	22%	Gaston	53%	42%	Pasquotank	31%	11%
Alleghany	65%	25%	Gates	50%	25%	Pender	69%	48%
Anson	50%	25%	Graham	40%	25%	Perquimans	66%	23%
Ashe	40%	20%	Granville	48%	23%	Person	55%	21%
Avery	44%	22%	Greene	35%	12%	Pitt	69%	53%
Beaufort	36%	27%	Guildford	49%	22%	Polk	37%	20%
Bertie	57%	27%	Halifax	41%	18%	Randolph	63%	39%
Bladen	58%	44%	Harnett	67%	14%	Richmond	43%	10%
Brunswick	40%	20%	Haywood	50%	25%	Robeson	65%	48%
Buncombe	33%	21%	Henderson	54%	21%	Rockingham	52%	34%
Burke	49%	27%	Hertford	34%	17%	Rowan	55%	29%
Cabarrus	58%	23%	Hoke	49%	23%	Rutherford	36%	8%
Caldwell	52%	29%	Hyde	88%	88%	Sampson	46%	37%
Camden	44%	22%	Iredell	32%	22%	Scotland	51%	29%
Carteret	49%	17%	Jackson	64%	33%	Stanly	48%	21%
Caswell	21%	5%	Johnston	48%	17%	Stokes	47%	29%
Catawba	51%	24%	Jones	22%	0%	Surry	68%	46%
Chatham	50%	26%	Lee	43%	28%	Swain	37%	22%
Cherokee	54%	20%	Lenoir	31%	14%	Transylvania	57%	34%
Chowan	32%	24%	Lincoln	50%	19%	Tyrrell	66%	66%
Clay	40%	25%	Macon	23%	12%	Union	55%	22%
Cleveland	32%	20%	Madison	39%	24%	Vance	38%	25%
Columbus	48%	19%	Martin	17%	1%	Wake	39%	15%
Craven	64%	27%	McDowell	69%	30%	Warren	32%	4%
Cumberland	39%	17%	Mecklenburg	49%	21%	Washington	53%	16%
Currituck	45%	10%	Mitchell	34%	17%	Watauga	45%	35%
Dare	61%	18%	Montgomery	36%	28%	Wayne	31%	20%
Davidson	50%	29%	Moore	53%	19%	Wilkes	47%	21%
Davie	56%	30%	Nash	27%	13%	Wilson	34%	23%
Duplin	38%	19%	New Hanover	40%	14%	Yadkin	61%	21%
Durham	38%	22%	Northampton	50%	22%	Yancey	47%	22%
Edgecombe	39%	18%	Onslow	55%	23%			
Forsyth	48%	21%	Orange	45%	21%			

** APS-R Charts are based on the APS 702-1 report with a run date of 07-01-2021*

Evaluation Timeframes

SFY Average # of days for Abuse	16.95	SFY Average # of days for Neglect	21.64	SFY Average # of days for Exploitation	27.87

County Name	ABS	NEG	EXP	County Name	ABS	NEG	EXP	County Name	ABS	NEG	EXP
Alamance	14.8	23	26.2	Franklin	0	24.8	34.3	Pamlico	0	14.6	0
Alexander	30	26	42.7	Gaston	22.2	22.6	28.9	Pasquotank	0	16.7	25.6
Alleghany	23	21.4	37.3	Gates	0	2	0	Pender	45	23	33.4
Anson	0	21.8	38.3	Graham	0	28.4	44	Perquimans	18	17.5	23.3
Ashe	0	20.5	0	Granville	16.7	20.6	27	Person	0	21	30.2
Avery	0	23	1	Greene	13	23.5	30.5	Pitt	27.2	26.3	30.6
Beaufort	34	22.1	21.8	Guildford	15	19.4	26.2	Polk	25	20.8	32.4
Bertie	27	25.9	22.4	Halifax	23	22.4	22.6	Randolph	11.6	13.5	22.9
Bladen	0	13.8	5.5	Harnett	29.7	25	28	Richmond	21	21.1	17.5
Brunswick	28.6	27.4	39	Haywood	18	18.8	23.8	Robeson	27.1	26.8	35.9
Buncombe	20.2	23.8	35.7	Henderson	25	20.2	26.2	Rockingham	21.6	12.4	22
Burke	25.9	27.7	34.5	Hertford	0	16.1	23	Rowan	29	25.6	39
Cabarrus	25	27.5	33.9	Hoke	24.5	23.6	32	Rutherford	15	19.3	21.5
Caldwell	19.4	26.3	34	Hyde	0	23.6	34	Sampson	27.6	26.2	33.4
Camden	0	26.5	20	Iredell	0	23.4	38	Scotland	43	15.3	18.5
Carteret	0	21.3	21.6	Jackson	22	19.3	20.7	Stanly	22.2	22.6	29.2
Caswell	15	19.1	27	Johnston	17.9	20.3	26.1	Stokes	14.5	13.7	20.5
Catawba	25	23.4	30.2	Jones	0	25.5	43	Surry	0	19.8	34.5
Chatham	28	28.9	41.6	Lee	16	19.9	36.5	Swain	21.5	17.8	25
Cherokee	13	22.4	28.6	Lenoir	28	16.6	0	Transylvania	0	17.5	23.9
Chowan	27	24.2	37.2	Lincoln	30.8	20.8	30	Tyrrell	0	21	0
Clay	20	21.7	32	Macon	0	24	41	Union	22.4	26.8	37.8
Cleveland	26	13.6	17.4	Madison	0	18	36.6	Vance	28	26.7	36.3
Columbus	28	24	32	Martin	16	17.7	29.7	Wake	26.5	23.4	31.3
Craven	21.4	17.6	31	McDowell	16	17.2	32	Warren	0	22.6	36.5
Cumberland	31.2	28.4	39.8	Mecklenburg	25.8	23.9	31.4	Washington	0	18.9	25.8
Currituck	0	27.6	41.5	Mitchell	0	22.5	42	Watauga	16	21.6	39.6
Dare	21	18.9	39	Montgomery	0	16.7	19.1	Wayne	18	18.4	27.9
Davidson	29	18.2	18.2	Moore	18.8	20.9	27.8	Wilkes	25.7	26	35.9
Davie	20	24.6	0	Nash	29	22.1	38.3	Wilson	27	26.4	29.8
Duplin	25.8	23.5	32.5	New Hanover	23.5	21.4	27.7	Yadkin	0	24.2	22.4
Durham	30.1	22.4	25.4	Northampton	0	24	0	Yancey	17	18.9	24
Edgecombe	30.5	25.2	28	Onslow	29.7	22.3	34.4				
Forsyth	21	24.6	34.2	Orange	25	23.8	36.2				

**APS-R Charts are based on APS 702-1 report with a run date of 07-01-2021.*

Initiation and Protection Timeframes

SFY average to initiate:	1.7 days	SFY average to provide protective services:	77.5 days

County Name	AVG # Days to Initiate	AVG # Days to provide PS	County Name	AVG # Days to Initiate	AVG # Days to provide PS	County Name	AVG # Days to initiate Eval	AVG # Days to provide PS
Alamance	1.4	75.2	Franklin	0.8	57.1	Pamlico	1	64
Alexander	1.6	93.7	Gaston	0.8	91.9	Pasquotank	1.1	61
Alleghany	0.6	68.9	Gates	1	0	Pender	1.3	65.3
Anson	1.9	62.2	Graham	0.7	202.6	Perquimans	1	9.7
Ashe	1.2	54.8	Granville	1.6	76.1	Person	1.2	65.4
Avery	1.7	0	Greene	1.6	25	Pitt	1.5	108.9
Beaufort	1.5	53.4	Guildford	1.4	151.6	Polk	1	66.9
Bertie	1.1	52.5	Halifax	1.5	42.1	Randolph	1.6	40
Bladen	0.6	85.2	Harnett	58.6	43	Richmond	0.8	56.6
Brunswick	1	108	Haywood	1.2	74.5	Robeson	0.4	79.6
Buncombe	1.3	70.6	Henderson	1.3	76.8	Rockingham	1.1	46.6
Burke	1.4	84.9	Hertford	1	70	Rowan	1.4	89.5
Cabarrus	0.9	136	Hoke	0.9	125.3	Rutherford	0.5	36
Caldwell	1	61	Hyde	1.3	59.5	Sampson	1	105.5
Camden	1.1	0	Iredell	1.2	127.2	Scotland	0.5	65.3
Carteret	1	44.5	Jackson	0.8	50.8	Stanly	1.5	56.2
Caswell	1	78.5	Johnston	1.2	67.9	Stokes	1.2	15.1
Catawba	1	86.1	Jones	1.3	247	Surry	0.7	76.5
Chatham	1.4	83.5	Lee	0.6	292	Swain	0.7	69.3
Cherokee	0.9	146.7	Lenoir	0.7	44.3	Transylvania	0.8	74.2
Chowan	1.4	91.8	Lincoln	0.8	106.7	Tyrrell	1.1	88.6
Clay	0.8	168.3	Macon	1.2	123.5	Union	1.3	95.7
Cleveland	1.2	63.4	Madison	1	66.7	Vance	1.2	99.7
Columbus	1.3	76	Martin	0.9	0	Wake	1.3	115.1
Craven	1	90.2	McDowell	0.9	31.3	Warren	0.7	65
Cumberland	1.7	112.3	Mecklenburg	1.2	80.2	Washington	0.7	80.5
Currituck	1.1	37	Mitchell	1	99.5	Watauga	1.4	65
Dare	1	81	Montgomery	1.1	40.8	Wayne	1.1	68.6
Davidson	0.7	86.5	Moore	0.8	43.9	Wilkes	0.9	83
Davie	1.3	61.3	Nash	1.6	92.7	Wilson	1.3	91.3
Duplin	5.5	55	New Hanover	1.4	93.4	Yadkin	1	71.5
Durham	1.3	72.6	Northampton	0.7	52.6	Yancey	0.8	22.6
Edgecombe	0.9	63.1	Onslow	1.2	81			
Forsyth	1.4	110.3	Orange	1	106.9			

** APS-R Charts are based on APS 702-1 report with a run date of 07-01-2021*

Adult Services Staffing in Departments of Social Services

Reported # of new Adult Services Social Workers in SFY 20-21	**159**
Average number of APS Supervisors per county	**1.8**

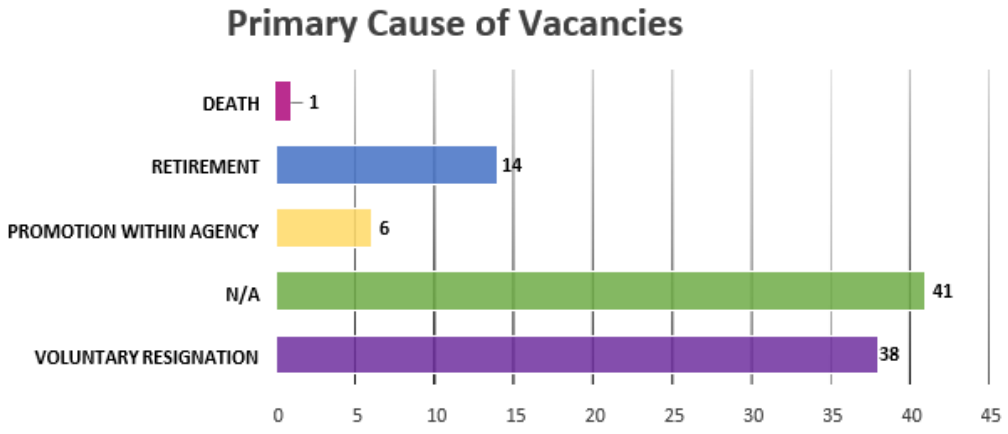
32%

of counties reported that their full-time employees work in **TWO** Adult Services programs

26%

of counties reported that their full-time employees work in **THREE** or more Adult Services programs

Vacancies	
# of Adult Service employees that left during SFY 20-21	**170**
Total # of current Adult Services vacancies	**86.5**



Counties reported that on average, 2 additional Adult Services employees would be needed in their offices to adequately address all of their programmatic needs.

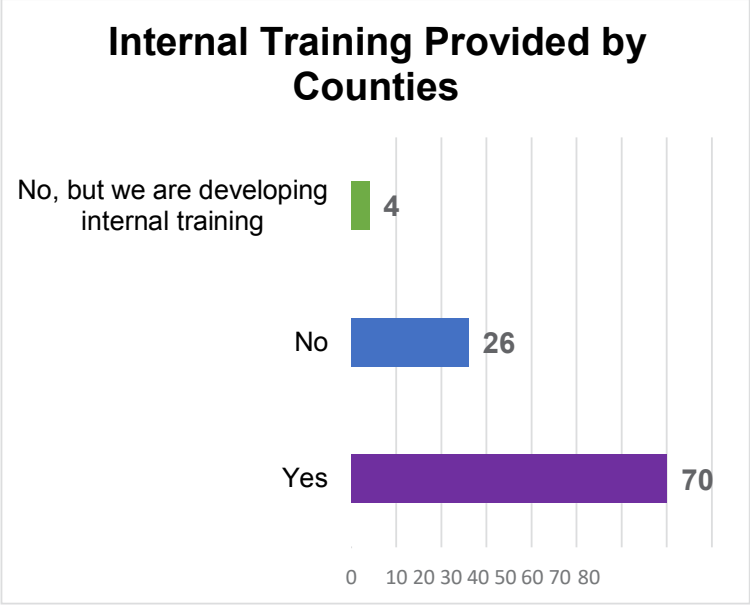
Adult Services Training

The Division of Aging and Adult Service provides basic skills and advanced level trainings for the following programs: Adult Protective Services, Guardianship, and Medicaid Administrative Claiming. For SFY 20-21, all trainings were conducted in the virtual environment and there were 2,731 training participants.

86% **Of Counties reported staff completed APS Basic Skills training and Fundamentals of Guardianship training**

Adult Services trainings received a 4.75/5.0 star rating based on completed training evaluations for SFY 20-21

70% of county departments of social services reported they provide internal training for their staff members.



Administration for Community Living

The Administration for Community Living (ACL) is committed to supporting Adult Protective Services efforts to ensure adults are afforded similar protections and services, regardless of their state or jurisdiction. The ACL developed the Voluntary Consensus Guidelines for State APS Systems through review and collaboration of all fifty states.

These guidelines provide a core set of principles and set expectations to encourage consistency in the policies and practices of APS programs across the country.

North Carolina has adopted these guidelines and incorporated them as part of the APS training objectives. These guidelines include recommendations in the following areas:

- Program Administration
- Time Frames
- Receiving Reports of Maltreatment
- Conducting the Investigation
- Service Planning and Service Implementation
- Training
- APS Program Performance

Multi-Disciplinary Teams (MDTs) also fall under Program Administration recommendations. MDTs convene in order to review complex maltreatment cases to increase effectiveness, satisfaction, rates of prosecution and a reduction in future maltreatment. Suggested partners are the county departments of social services, local health departments, district attorneys, law enforcement, medical providers, hospital staff, LME/MCOs, and other community partners.

58 counties do not have an MDT

30 counties have an MDT

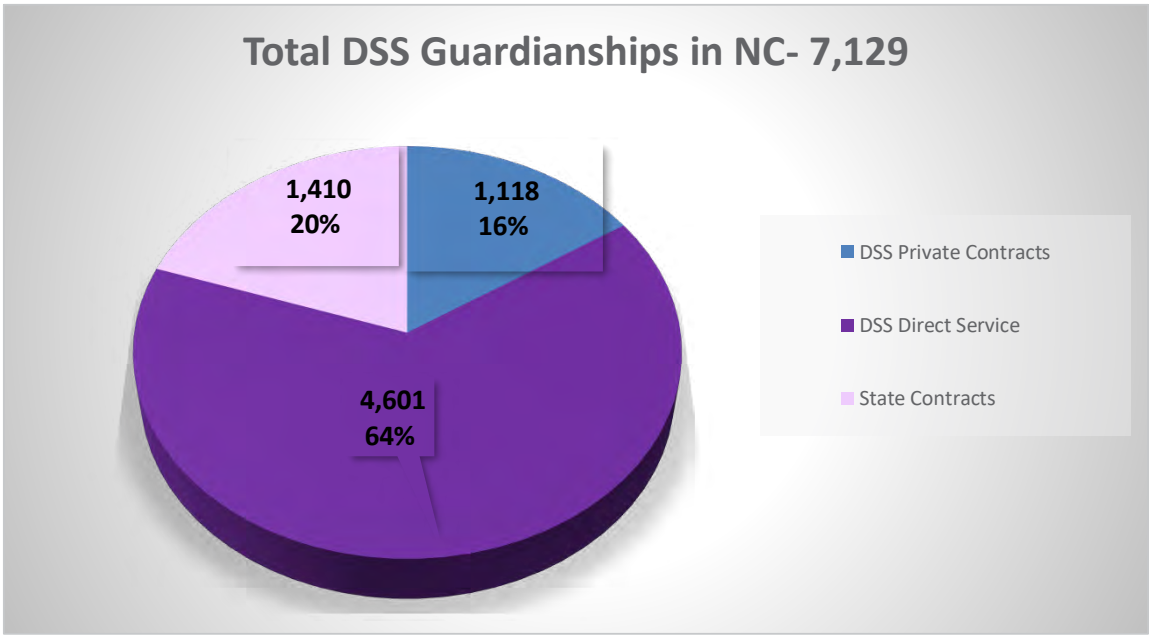
12 counties are developing an MDT

Guardianship

Adult guardianship is governed by North Carolina General Statute 35A. County departments of social services Directors are the only statutorily defined disinterested public agent guardians (DPAG). County DSS Directors are often the guardian for many individuals throughout the state, making decisions about their person or estate, for the best interest of the individual under guardianship.

There are three types of guardianship appointments:

1. Guardianship of the Person- involves making decisions about the individual's medical procedures, placement, and overall wellbeing.
2. Guardianship of the Estate- involves management of the individual's property and financial resources.
3. General Guardian- has the responsibility of both the person and estate decisions.



Guardianship and Contracting with Private Corporations

County Departments of Social Services Contracts

County departments of social services may contract with a private guardianship corporation to provide guardianship to incompetent adults. As of state fiscal year 2020 – 2021 there were **1,118 individuals served** through these private contracts.

33 counties contracted with a private corporation

65 counties did not contract with a private corporation

Statewide, counties spent **$3,150,701.14** total on these contracts; and 28% of the funding was provided by county dollars.

State Contracts

DAAS, on behalf of county DSS, manages contracts for **1,410 individuals** served by one of six private guardianship corporations. Each corporation has a specific number of individuals that they contractually serve. The corporations are:

- The Arc of North Carolina
- Empowering Lives Guardianship Services
- Hope for the Future
- Phoenix Counseling
- GGems
- Case Management Services

Funding for these contracts is appropriated from the Social Services Block Grant (SSBG) and totals $4,356,604.

**Data collected through AS Annual Survey.*

Guardianship and Contracting with Private Corporations

9.1

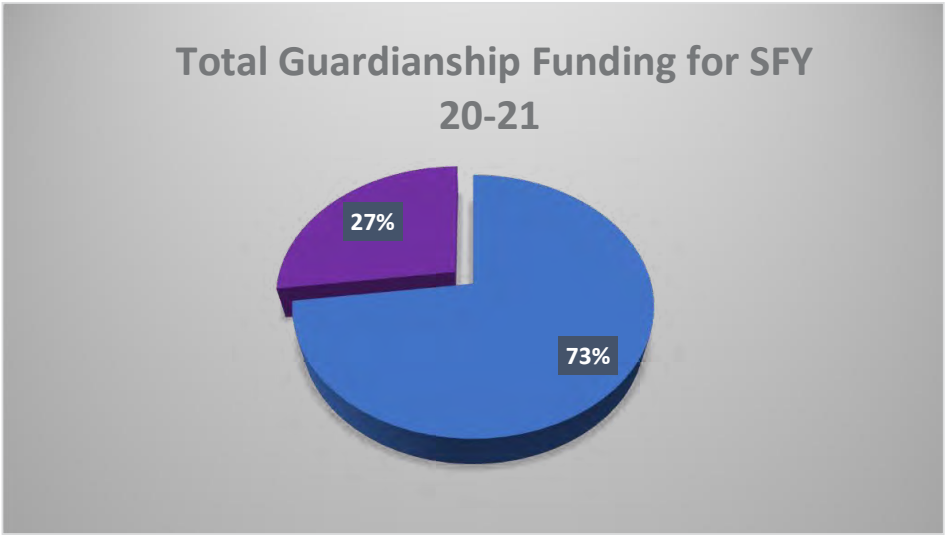
was the average monthly caseload size for county DSS staff in SIS Code 107 (Guardianship Services)

**Data collected through AS Annual Survey*

Guardianship Funding

The guardianship program is also funded through the Social Services Block Grant (SSBG). This funds county staff time who work with this vulnerable population who often have both physical and mental health diagnosis. The funding is often depleted quickly in the state fiscal year leaving county funding to cover the cost of providing this statutorily mandated program.

County	Federal-SSBG
$15,689,570.41	$5,825,838.30
73%	27%



Special Assistance In Home

The Special Assistance In Home (SAIH) program was created for individuals who may need care in a facility, but who can remain safely in a private living arrangement (PLA), if provided with sufficient income, adequate housing, necessary health and social services, reliable informal support from family and friends, and case management services.

The N.C. General Assembly recognized this as a viable option when it passed a special provision in Session Law 1999 237 authorizing the SAIH Program, and then making it a permanent statutory program in 2007.

The goal of the SAIH program is to allow eligible individuals to remain in the community and live as independently as possible. The SAIH payment is an income supplement, and is intended to assist with the provision of daily necessities such as food, shelter, clothing, utilities, transportation, in-home aide services, essential household items, essential home repairs and modifications and other services that enable the client to live at home safely. The purpose of the SAIH payment is to help eligible individuals meet their basic financial needs.

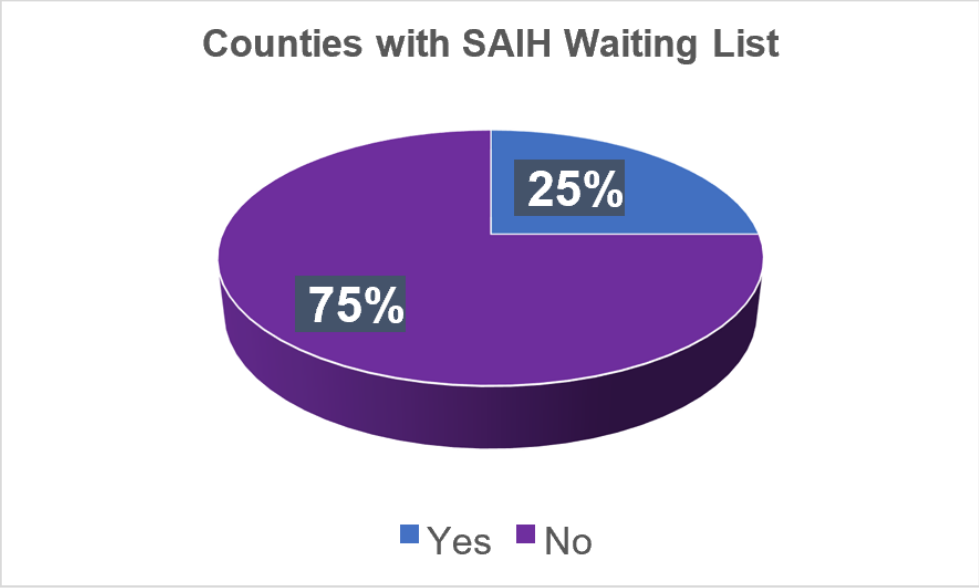
# of designated staff for SAIH Case Management	Average monthly caseload for staff responsible for SAIH Program
199 Staff	12.28 Cases

Special Assistance In Home - Waiting Lists

County departments of social services face barriers while providing the Special Assistance In Home (SAIH) program. Some of those barriers include additional funding for staff, large caseload sizes, community education about the program, and the COVID-19 pandemic.

While these barriers have posed challenges, the SAIH program has proven to be a value to many older and disabled adults. The SAIH program can provide the ability for individuals to stay in their homes with the necessary supports and can prevent maltreatment to include abuse, neglect, and exploitation. Counties reported that a lack of funding for additional staff and staff having multi-program responsibilities as leading barriers to increasing SAIH cases. 25% of NC counties reported having a SAIH waiting list in SFY 20-21.

There was a total of **632** adults on those SAIH waiting lists.



Special Assistance In Home - Active Cases

Totals for Current Active Cases:	3,060	Totals for TCL:	1,056

County Name	Current Active Cases	TCL	County Name	Current Active Cases	TCL	County Name	Current Active Cases	TCL
Alamance	12	14	Franklin	25	6	Pamlico	3	0
Alexander	4	1	Gaston	61	35	Pasquotank	67	2
Alleghany	1	0	Gates	2	0	Pender	10	0
Anson	7	0	Graham	13	0	Perquimans	3	0
Ashe	22	0	Granville	12	3	Person	11	3
Avery	2	0	Greene	8	0	Pitt	19	4
Beaufort	88	0	Guildford	193	34	Polk	0	0
Bertie	8	0	Halifax	32	15	Randolph	23	0
Bladen	42	3	Harnett	40	19	Richmond	4	10
Brunswick	26	0	Haywood	19	5	Robeson	101	35
Buncombe	22	132	Henderson	117	12	Rockingham	31	0
Burke	77	38	Hertford	20	0	Rowan	31	8
Cabarrus	113	17	Hoke	25	0	Rutherford	11	15
Caldwell	33	11	Hyde	2	0	Sampson	15	4
Camden	1	0	Iredell	17	2	Scotland	11	8
Carteret	41	0	Jackson	7	0	Stanly	8	7
Caswell	13	0	Johnston	46	0	Stokes	57	0
Catawba	73	8	Jones	3	0	Surry	29	3
Chatham	21	0	Lee	0	1	Swain	4	0
Cherokee	1	0	Lenoir	29	0	Transylvania	14	3
Chowan	2	0	Lincoln	38	8	Tyrrell	1	0
Clay	0	0	Macon	1	1	Union	6	3
Cleveland	61	10	Madison	3	0	Vance	27	1
Columbus	30	5	Martin	8	0	Wake	139	99
Craven	24	16	McDowell	40	8	Warren	6	0
Cumberland	68	1	Mecklenburg	391	251	Washington	0	0
Currituck	15	0	Mitchell	1	1	Watauga	14	0
Dare	19	0	Montgomery	21	0	Wayne	19	16
Davidson	15	1	Moore	16	4	Wilkes	5	1
Davie	16	4	Nash	18	10	Wilson	28	1
Duplin	10	0	New Hanover	50	96	Yadkin	5	1
Durham	124	8	Northampton	18	0	Yancey	0	0
Edgecombe	14	5	Onslow	24	0			
Forsyth	39	35	Orange	14	12			

**TCL numbers are based on the data that has been entered into the NC FAST system.*

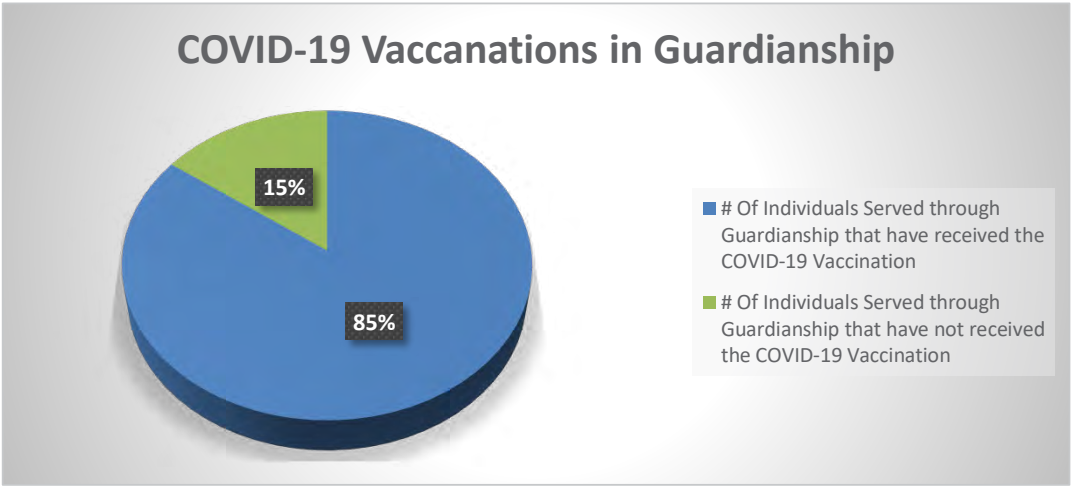
Special Assistance Facility Cases
Total: 13,923

County Name	Facility Cases	County Name	Facility Cases	County Name	Current Active Cases
Alamance	315	Franklin	76	Pamlico	23
Alexander	41	Gaston	361	Pasquotank	117
Alleghany	19	Gates	29	Pender	62
Anson	57	Graham	5	Perquimans	33
Ashe	71	Granville	73	Person	122
Avery	36	Greene	49	Pitt	303
Beaufort	97	Guildford	602	Polk	22
Bertie	62	Halifax	135	Randolph	193
Bladen	73	Harnett	178	Richmond	91
Brunswick	89	Haywood	117	Robeson	310
Buncombe	377	Henderson	155	Rockingham	239
Burke	172	Hertford	94	Rowan	156
Cabarrus	210	Hoke	67	Rutherford	166
Caldwell	144	Hyde	8	Sampson	136
Camden	16	Iredell	208	Scotland	73
Carteret	82	Jackson	51	Stanly	123
Caswell	56	Johnston	307	Stokes	87
Catawba	247	Jones	13	Surry	165
Chatham	80	Lee	77	Swain	25
Cherokee	57	Lenoir	153	Transylvania	52
Chowan	37	Lincoln	103	Tyrrell	10
Clay	22	Macon	57	Union	181
Cleveland	236	Madison	34	Vance	70
Columbus	106	Martin	66	Wake	788
Craven	115	McDowell	95	Warren	46
Cumberland	455	Mecklenburg	704	Washington	30
Currituck	29	Mitchell	33	Watauga	46
Dare	54	Montgomery	53	Wayne	240
Davidson	274	Moore	153	Wilkes	116
Davie	62	Nash	187	Wilson	160
Duplin	102	New Hanover	212	Yadkin	53
Durham	373	Northampton	70	Yancey	22
Edgecombe	161	Onslow	148		
Forsyth	522	Orange	141		

** TCL numbers are based on the data that has been entered into the NC FAST system.*

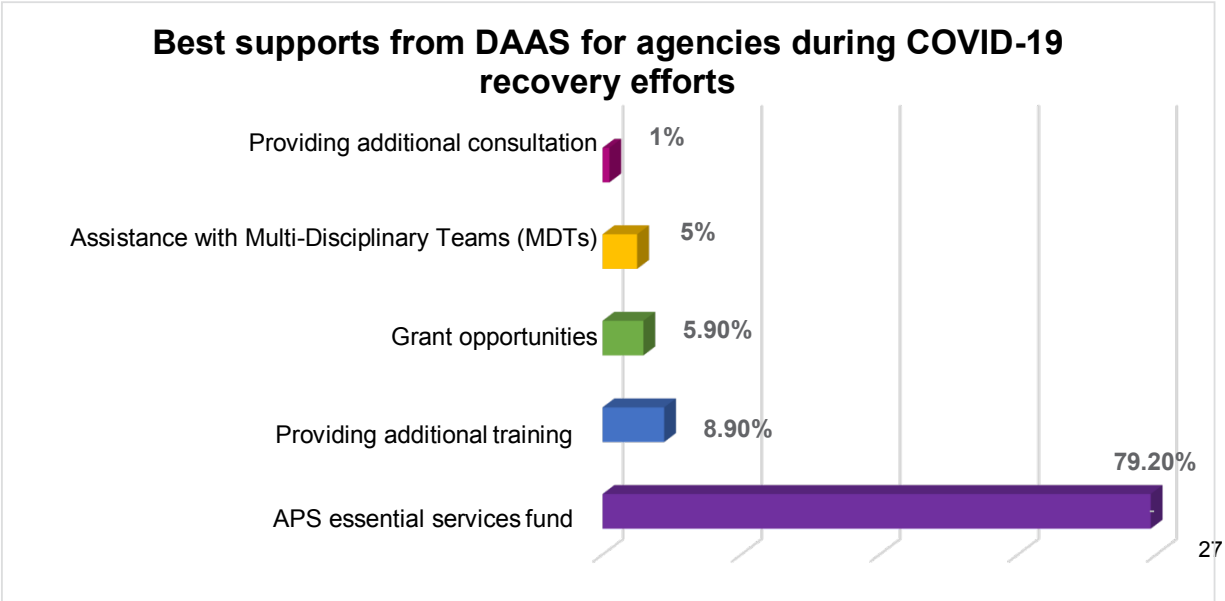
COVID-19 IMPACT

The onset of the COVID-19 pandemic resulted in an unprecedented crisis for county departments of social services. The safety of both county staff and the citizens they serve, some of the most vulnerable, was and is paramount. The obstacles faced by the counties were staff fatigue, social isolation crises for adults, transportation needs, and lack of housing availability for individuals.



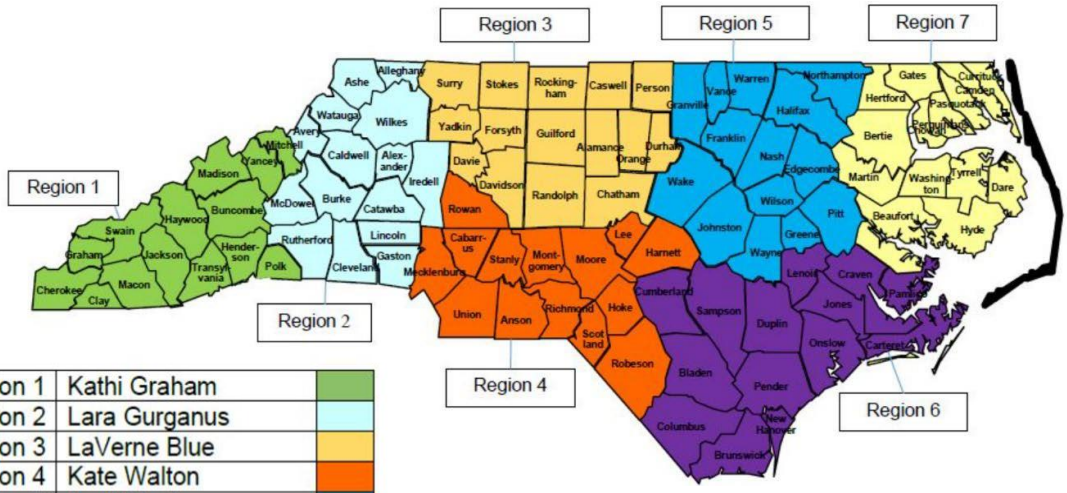
# Of APS Evaluations Involving COVID-19 Positive Individuals	1,036

**Estimated by each Count*



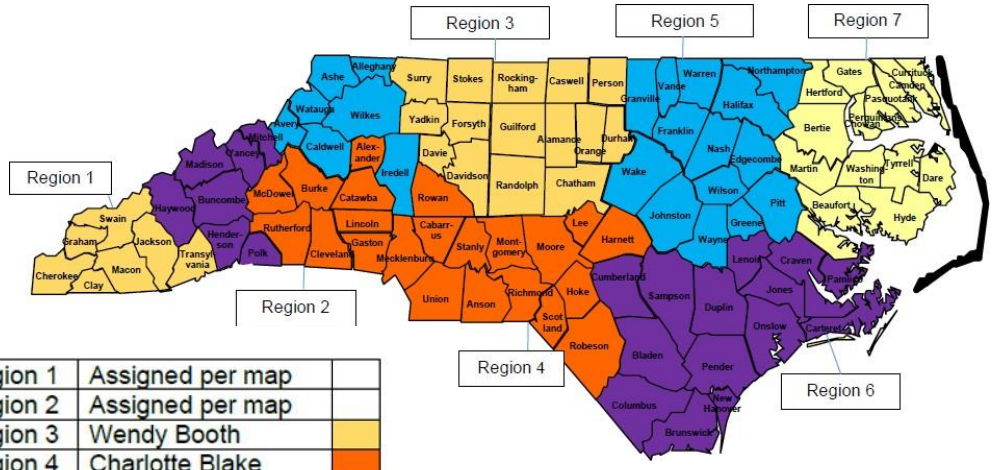
NC Coverage Maps for
Continuous Quality Improvement Specialist (CQIs)

Adult Services



Region 1	Kathi Graham
Region 2	Lara Gurganus
Region 3	LaVerne Blue
Region 4	Kate Walton
Region 5	April Black
Region 6	Joann Windley
Region 7	Vacant

Special Assistance

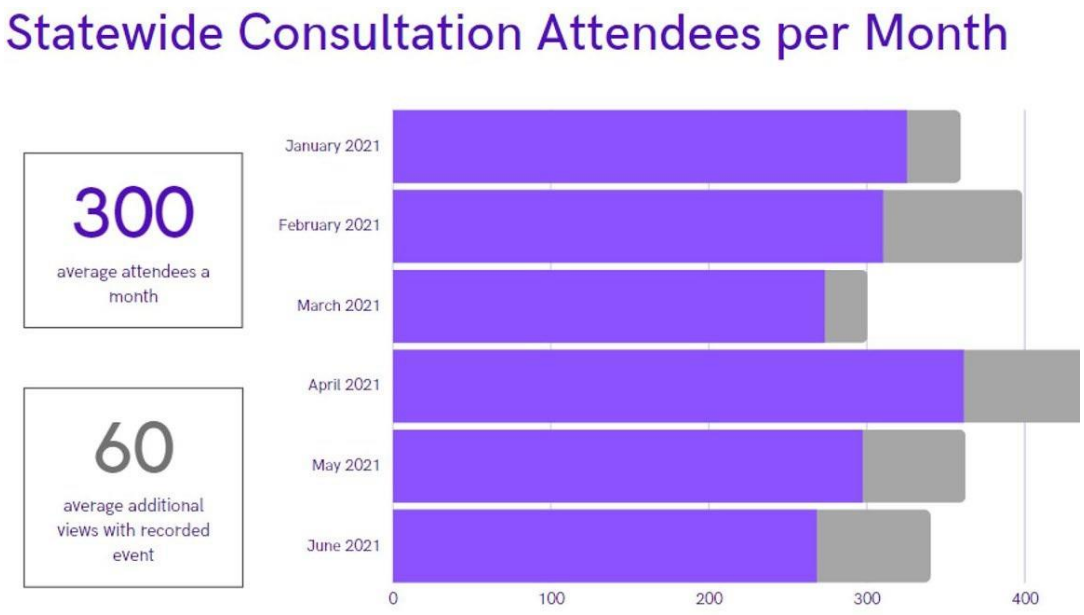


Region 1	Assigned per map
Region 2	Assigned per map
Region 3	Wendy Booth
Region 4	Charlotte Blake
Region 5	Latesha Haddock
Region 6	Suzanne Harlow
Region 7	Valerie Williams

Statewide Monthly Consultation Meetings

Statewide Monthly Consultations were a new form of communication for SYF 20-21. Statewide Consultations allow DAAS staff to communicate effectively and efficiently with all 100 County DSS's in one setting. Average attendance for SFY 20-21 was 300 attendees. The largest attended statewide consult to date was 488 attendees.

This type of consult allows DAAS to conduct continuous quality improvement updates, special presentations, and In-Services in Microsoft LIVE.



Join us every 4th Thursday, or listen to our recordings on the DAAS SharePoint Site.

Special Assistance Adult Services (SAAS) SharePoint

In SFY 20-21 DAAS launched the Special Assistance Adult Services SharePoint site. We have been able to host a wealth of information on this site. The site has allowed DAAS to have a “one stop shop” for all things Adult Services and Special Assistance related.

Components of the SharePoint Site include:

Training

- DAAS Training Dates and Registration Links
- DAAS Training Materials for Participants

Programmatic

- Adult Services CQI Consultation Information by region
- Adult Services CQI and Monitoring Tools
- Performance Measures
- Special Assistance Hub
- Statewide Consultation Information including in-services presentations
- And more!

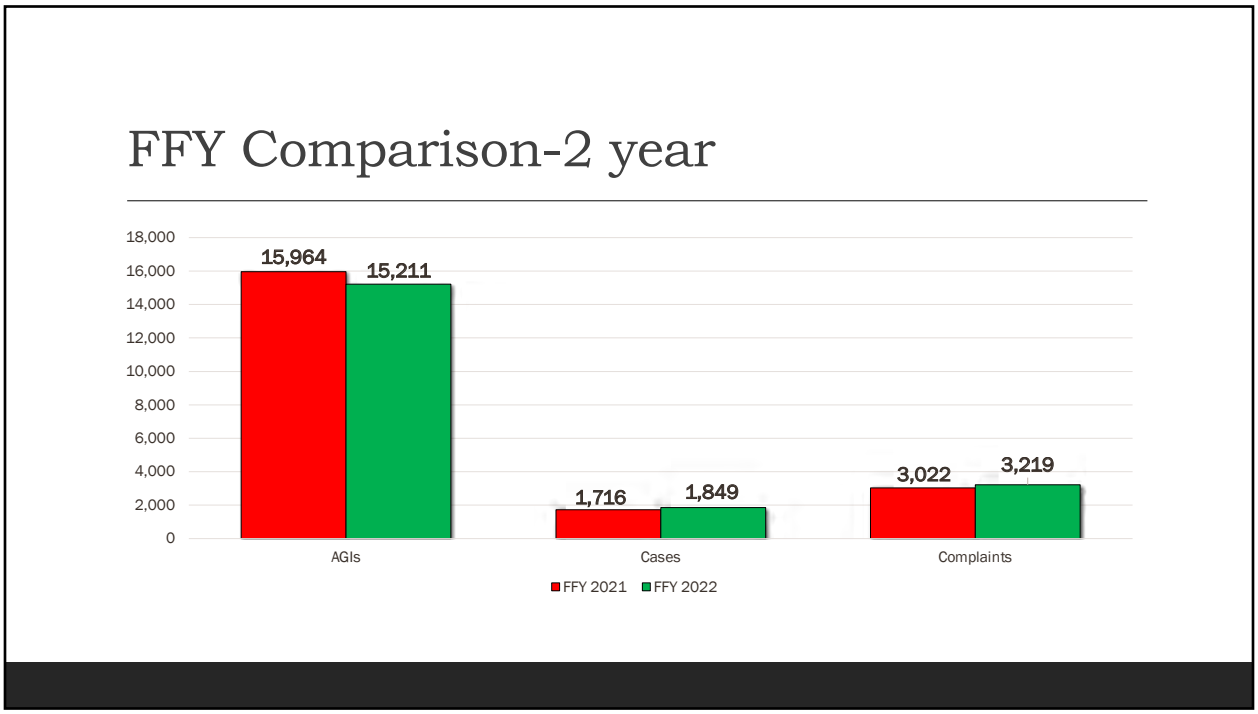
These views are the total since the launch on 1/26/2021.

If you have not joined the SAAS SharePoint yet, make sure you contact your Adult Services Program Supervisor to be added via the monthly survey.

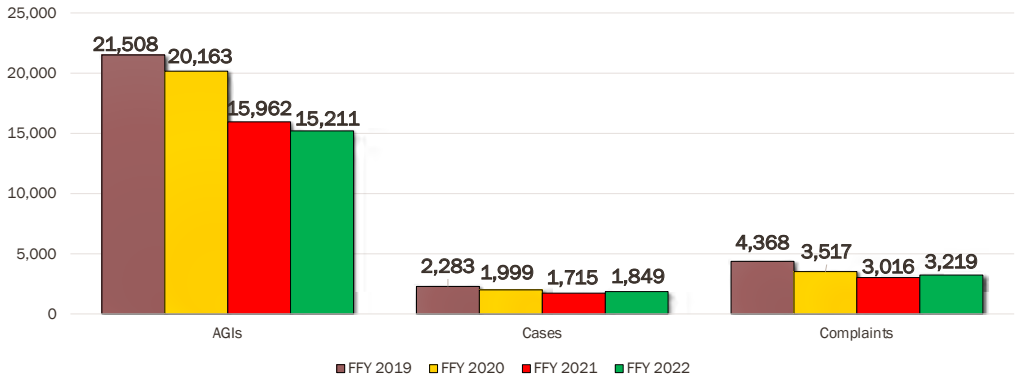
N. OMBUDSMAN PROGRAM OVERVIEW DATA

Quarterly Comparison

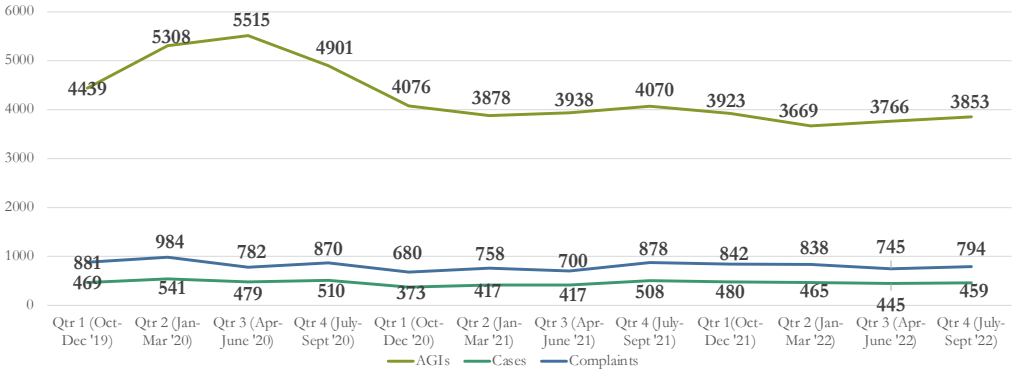
FFY 2021	Q1	Q2	Q3	Q4
CASES	374	418	416	508
COMPLAINTS	685	759	700	878
AGIs	4,082	3,878	3,937	4,067
FFY 2022	**Q1**	**Q2**	**Q3**	**Q4**
CASES	480	465	445	459
COMPLAINTS	842	838	745	794
AGIs	3,923	3,669	3,766	3,853



FFY (4-yr) Comparison

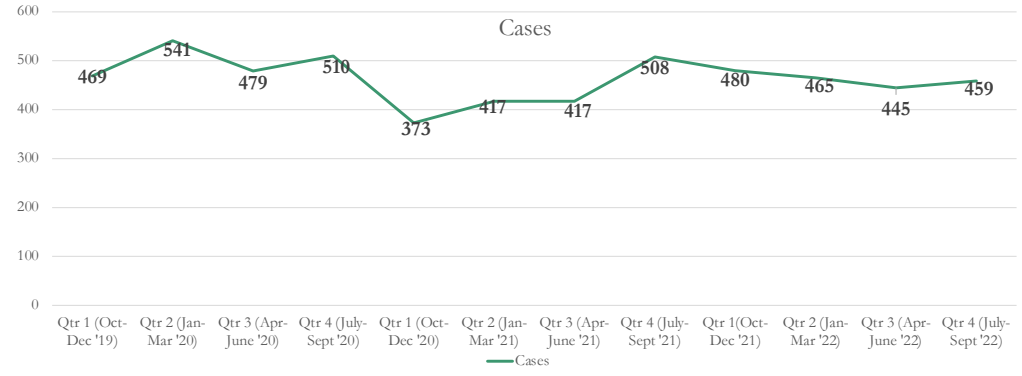


Impact from COVID-19

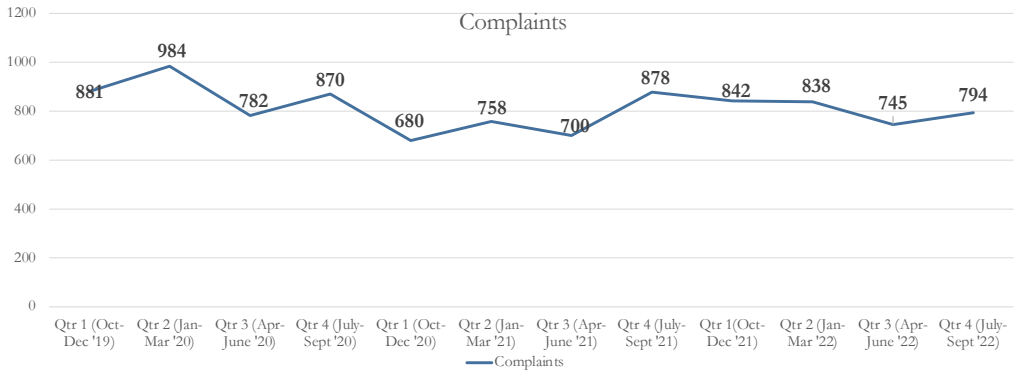


A Closer Look….(AGIs)

A Closer Look….(Cases)



A Closer Look….(Complaints)



Complainant Comparison

Complainant	FFY 2019	FFY 2019, % by total	FFY 2020	FFY 2020, % by total	FFY 2021	FFY 2021, % by total	FFY 2022	FFY 2022, % by total
Total cases closed	**2,257**		**2,115**		**1,769**		**1,873**	
Resident	1,137	50.38%	905	42.79%	686	38.78%	821	43.83%
Resident representative, friend, family	819	36.29%	930	43.97%	910	51.44%	839	44.79%
Ombudsman Program	142	6.29%	117	5.53%	58	3.28%	78	4.16%
Facility staff	64	2.84%	54	2.55%	34	1.92%	42	2.24%
Representative of other agency or program	49	2.17%	73	3.45%	54	3.05%	59	3.15%
Concerned Person	6	0.27%	29	1.37%	26	1.47%	31	1.66%
Resident or Family Council	N/A	N/A	7	0.33%	1	0.06%	3	0.16%
Unknown	40	1.77%	0	0.00%	0	0.00%	0	0.00%

*Complainant-an individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, long-term care residents

Disposition Comparison

Disposition	FFY 2019	FFY 2019, % by total	FFY 2020	FFY 2020, % by total	FFY 2021	FFY 2021, % by total	FFY 2022	FFY 2022, % by total
Total complaints	**4,440**		**3,448**		**2,983**		**3,238**	
Partially or fully resolved to the satisfaction of the resident, resident representative or complainant	2,758	62.12%	2,650	76.86%	2,266	75.96%	2,290	70.72%
Withdrawn or no action needed by the resident, resident representative or complainant	1,124	25.32%	334	9.69%	253	8.48%	622	19.21%
Not resolved to the satisfaction of the resident, resident representative or complainant	263	5.92%	464	13.46%	464	15.55%	326	10.07%
Legacy dispositions (aggregated)	295	0.00%	0	0.00%	0	0.00%	0	0.00%

THE STATE OF **Older Adult Food Insecurity** AND **Malnutrition** IN NORTH CAROLINA

The unprecedented growth in North Carolina's older adult population and the COVID-19 pandemic have exacerbated the issues of older adult food insecurity and malnutrition, increased the number of older adults needing food and nutrition services, and complicated the ability for existing programs to provide services to older adults in need.

This document, with key data on state demographics, food insecurity and malnutrition, is intended to function as a catalyst for the development of action plans and coordinated efforts of partner organizations and agencies to help address these issues among older adults in North Carolina.

State Demographics & Characteristics of Older Adults in North Carolina

POPULATION DEMOGRAPHICS OF OLDER ADULTS IN NC (2020)[1]

Ranked **ninth in the US for total population** and **eighth in population of age 65 and older**

- **17%** (1,760,844) of 10,456,593 **total population**
- **23%** (2,406,444) of 10,456,593 **were age 60+**

As of 2019, the population of persons over 60 is now **larger than the population** of persons under 18 years of age.

- By 2028, **one in five** North Carolinians will be 65+
- In the next two decades, the 65 and older population will increase from 1.7 to 2.7 million, **a projected growth of 52%**.
- Projected growth among the age groups 65-74 (25%), 75-84 (88%) and 85+ (116%) indicates that **there will be an increased proportion of older adults in the state**, creating challenges for long-term services & supports.

93.5% live in the community

9.2% live below the poverty line

43% live in single person households

42% of the estimated 87,329 grandparents responsible for grandchildren under 18 were age 60+

HEALTH CHARACTERISTICS OF OLDER ADULTS IN NC (2020)[2,6]

81%
have at least **one chronic condition**

54%
have **2 or more chronic conditions**

41.1%
have 4 or more **chronic conditions**

34.5%
have at least **one disability**

FACTORS CONTRIBUTING TO OLDER ADULT FOOD INSECURITY AND MALNUTRITION[3]

- Poverty
- Racial and ethnic minorities
- Chronic conditions
- Disabilities
- Food deserts
- Transportation/ Mobility challenges
- Living alone
- Living with grandchildren
- Social isolation

DEFINITIONS[4,5]

Food Insecurity is a household-level economic and social condition of limited or uncertain access to adequate food. (USDA)

Malnutrition is deficiencies, excesses or imbalances in a person's intake of energy and/or nutrients. (WHO)

Hunger is prolonged, involuntary lack of food, discomfort, weakness, illness. An individual-level physiological condition that may result from food insecurity. (USDA)

Food Insecurity

Studies indicate a correlation between household food insecurity and a decline in functional health, creating barriers to self-care management for those with chronic conditions. This increases the possibility of negative disease outcomes and greater high-cost healthcare utilization.[10]

In 2019, **177,967 (7.5%) of older adults age 60 and older in NC** were food insecure.[1] In 2020, **NC had the 14th highest rate of food insecurity** in the US.[3]

Number of Older Adults Served by Older Americans Act (OAA) Nutrition Program in 2020[7]

- Congregate Meals: **23,177**
- Home Delivered Meals: **19,829**

USDA Food and Nutrition Service (FNS) Statistics (Feb. 2021)[8]

- NC Participation Rate among eligible 55+: **59%**
- NC monthly allotment average 55+: **$108.51**

USDA Supplemental Nutrition Assistance Program (SNAP) **reduces nursing home admission and hospitalization rates**[9]

Cost Comparisons (North Carolina)[6]

- One **home-delivered meal: $9.84**
- One **congregate meal: $8.85**
- One **day in a hospital: $2,236**
- One **day in a nursing home: $240**

Many low income older adults face spending trade-offs that can lead to and worsen food insecurity (e.g. housing, utilities, transportation, health care)

NC PROGRAMS ADDRESSING OLDER ADULT FOOD INSECURITY

- Senior Nutrition Program
  - Congregate nutrition program
  - Home-delivered meals program
- Supplemental Nutrition Assistance Program (SNAP)
- Commodity Supplemental Food Program (CSFP)
- Food Banks and food pantries
- Farmers Markets, community gardens
- Senior Farmers Market Nutrition Program
- Local food policy councils
- Faith-based groups (e.g. NCBAM – Serving Hope)

Though helpful, these programs are not currently able to fully meet the needs of the North Carolina's food insecure older adults.

11, 12 & adapted with updated data

Malnutrition

Malnutrition is an under-recognized but growing health crisis for older adults in the US and a burden to the state economy. There are currently no national or state public health goals on malnutrition, and malnutrition quality measures are not included in quality incentive programs.[13]

$140,348,592 = annual costs

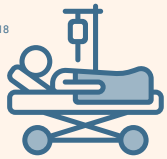
of disease-associated malnutrition for adults 65+ in NC[14]

Hospital nutritional interventions substantially **improve patient outcomes and reduce costs**[15, 16]

- **22% reduction** in length of stay
- **71% reduction** in lost hospital revenue per patient
- **17% reduction** in readmission costs
- **5% reduction** in readmission rate

REDUCED COSTS

UNC Hospitals BRIDGE Study[17, 18]



- **Building Resilience InDependence for Geriatric Patients in the ED**
- **Over 50% of Emergency Department (ED) patients age 65+** were malnourished or at risk of malnutrition
- **Over half of these patients** had not been diagnosed previously
- **Phase 1:** identifying malnutrition and food insecurity screening tools for ED and completing feasibility testing
- **Phase 2:** partnering with Area Agencies on Aging to help patients at risk for malnutrition and food insecurity

Recent Updates

- The **reauthorization of the Older Americans Act** added malnutrition screening and prevention
- The **new Dietary Guidelines for Americans** added older adults and mentioned malnutrition and sarcopenia for the first time

MALNUTRITION: AN OLDER ADULT CRISIS

UP TO 1 OUT OF 2 OLDER ADULTS are at risk for malnutrition[1]

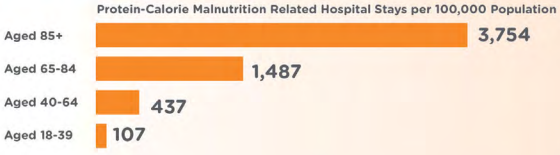
$51.3 BILLION Estimated annual cost of disease-associated malnutrition in older adults in the US[2]

Protein-calorie malnutrition related hospital stays are **2X LONGER**[3]

MALNUTRITION LEADS TO more complications, falls, and 30-day readmissions[3,4]

Protein-calorie malnutrition related hospital stays are **3X MORE LIKELY** to result in death[3]

MALNUTRITION IS HIGHEST IN OLDER ADULTS[3]



JUST 4 STEPS CAN HELP IMPROVE OLDER ADULT MALNUTRITION CARE[19]

SCREEN all patients

+

ASSESS nutritional status

+

DIAGNOSE malnutrition

+

INTERVENE with appropriate nutrition

FOCUSING ON MALNUTRITION IN HEALTHCARE HELPS:

- ✓ Decrease healthcare costs[5]
- ✓ Improve patient outcomes[5]
- ✓ Reduce readmissions
- ✓ Support healthy aging
- ✓ Improve quality of healthcare

Opportunities for Involvement

- Educate and raise awareness about older adult food insecurity and malnutrition
- Support community partners and promote community nutrition and food access
- Strengthen SNAP policies for older adults
- Support SNAP-Ed, SNAP Outreach, simplify application process
- Advocate for increases to NC Senior Farmers Market Nutrition Program funding
- Implement improvements to discharge planning so health plans include providing nutritious meals
- Strengthen Food Security Screening Referral Process
- State policy actions, including:
  - Recognition of Malnutrition Awareness Week through a resolution/proclamation
  - Inclusion of malnutrition care in state healthcare quality improvement initiatives
  - Establishment of a malnutrition prevention commission for older adults
- **Bring together government, private sector, nonprofits, philanthropic, and other groups working on solutions – *GET INVOLVED IN THE NC SENIOR HUNGER INITIATIVE***

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FOR MORE INFORMATION, CONTACT:
Audrey Edmisten, RD, LDN, MPH
NC Department of Health and Human Services
Division of Aging and Adult Services
audrey.edmisten@dhhs.nc.gov

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DAAS Emergency Operations Plan, 2022-2023

Table of Contents

Acronyms

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

I. Mission

To assure that the Division of Aging and Adult Services, hereinafter referred to as the Division, and the aging and adult services network will address the functional and access needs of older people and adults with disabilities in preparation for and during times of disaster and recovery.

II. Authority for Disaster Role

A. Older Americans Act References

Section 307 (a)

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

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

B. United States Administration on Aging (AoA)

Emergency Preparedness and Response (2010)

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

It is critical that:

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

III. Division Responsibilities

A. Efforts for Preparedness, Response and Recovery

The N.C.G.S. §143B-181.1 reads: "the Division of Aging (and Adult Services) is designated as the state unit on aging as defined in the federal Older Americans Act of 1965, as amended, and shall exercise all responsibilities pursuant to that act", North Carolina General Statutes 166A "North

Carolina Emergency Management Act of 1977" sets forth the authority and responsibility of the Governor, State agencies, and local governments in prevention of, preparation for, response to and recovery from natural or man-made disasters or hostile military or paramilitary action to:

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

B. State Emergency Operations Plan

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

- Promote the exchange of technical and statistical information relevant to needs and outcomes of the aging and disability populations from North Carolina Emergency Management (NCEM) to area agencies on aging and county departments of social services;
- Collaborate as requested with NCEM Emergency Support Function-6 (ESF-6), Division of Social Services and other human service agencies to assist local jurisdictions in meeting the needs of individuals needing functional support sheltering services;
- Collaborate as requested with NCEM (ESF-8), Division of Health Service Regulation and Division of Public Health, for individuals needing medical support sheltering services; and
- Support recovery efforts by assigning and deploying appropriate personnel to assist county departments of social services, area agencies on aging and other local entities as requested.

IV. Advanced Planning

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

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

- DIRM Contact Representative.
- Director of the Division of Aging and Adult Services.
- Emergency Coordinating Officer.
- Section Chiefs: Adult Services, Service Operations, and Elder Rights.
- Division Supervisors; and
- Other Staff

Information to be disseminated:

- Announce the activation of the Division's disaster plan.
- Inform staff members of the situation.
- Announce plans for interruptions in day-to-day operations; and
- Convey other pertinent information as necessary.

Planning for circumstances which may directly or indirectly affect area agencies on aging, departments of social services and other local agencies must occur prior to a disaster.

Responsibilities of the Division during the advanced planning stage include:

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

V. Preparedness

A. Call-Down System

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

In an effort to communicate the details of the impending event to regional offices, the Division/AAA Liaisons and the Ombudsman Support Coordinator will do a call down using the Pre-Event Call Down report to the AAA, 72 hours in advance and as conditions change, in the affected regions. AAA's will be responsible for:

- Informing staff and adjusting to maintain operation.
- Reviewing the local disaster plan and contacting local emergency management.
- Calling local service providers; and determining overall readiness and making final preparations for interruptions in operations.

B. Reporting by Aging and Adult Services Networks

Uniform, essential information recorded on the Pre-Event and Post Event reporting forms by the AAAs and Service provider network may be needed on a daily basis by the Division before, during, and after every disaster concerning:

- Status of older people and adults with disabilities and their known or anticipated needs;
- Approximate locations and numbers of affected older people and adults with disabilities; and
- Status of immediate and anticipated needs of aging and adult service providers and AAA's.

AAAs will work with the local service providers to assure that contact is made with older adults who may be on a functional needs registry or otherwise isolated and require more personal communication to help ensure safety during and following the event. Information from this contact will be recorded and relayed to the Division when needs cannot be met with local resources.

VI. Response

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

The Division/AAA Liaison responsibilities include:

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

AAA responsibilities include:

- Coordinating daily responses to Division/AAA Liaison reporting requests;
- Determining changes needed to assignments as a result of the disaster;
- Maintaining a log of requests, responses, and referrals; and,
- Continued coordination with local emergency management for requests for assistance.

VII. Recovery

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

Division responsibilities during recovery include:

- Advocate for older people and adults with disabilities who have become victims;
- Assist with personnel outreach/field assistance; and
- Provide support for grant opportunities and special initiatives.

Area Agency on Agency responsibilities during recovery include:

- Assess status of older people and adults with disabilities and service providers;
- Assisting with resources, information and outreach;
- Coordination with local emergency management, other local agencies and volunteer organizations; and
- Debrief staff and evaluate the results to determine necessary changes in the county disaster plans.

VIII. Staff

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

A. Disaster Team

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

The Active Disaster Team will include the Adult Services Coordinator, the Ombudsman Support Coordinator and Division/AAA Liaisons.

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

- Triggers activities of the Division Disaster Team.
- Serves as primary point of contact with the DHHS lead agency.
- Serves as primary intermediary with the US Administration on Aging.
- Represents the Division at NCEM/SERT meetings.
- Coordinates the Division field assistance.
- Assures regular Division disaster team/general staff meetings; and
- Coordinates publicity and press releases.

Serves as primary point of contact for Emergency Management; and Assists the aging network with special grant proposals.

Disaster Preparedness and Recovery

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

Non-Emergency Related Duties in Support of Emergency Operations:

- Updates the Division disaster contact list and AAA contact list annually in June;
- Represents the Division at DHHS meetings, general disaster meetings and committees as needed;
- Coordinates updating of disaster plan and operating procedures for the Division as required;
- Keeps the Disaster Notebooks up-to-date;
- Assists with standardizing forms and procedures for reports by AAA's and service providers as requested;
- Assists the aging and adult services network in updating their disaster plans as requested; and
- Coordinates maintenance and updating of disaster information on the Division website in conjunction with the Division web master.

Adult Services Coordinator

- Coordinates status reports with Division of Social Services while in the Emergency Operations Center; and
- Collaborates as requested with state and county Functional and Medical Support Population Coordinators- ESF 6 and ESF 8.

Ombudsman Support Coordinator

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

The Division/AAA Liaisons, Ombudsman Support Coordinator, Adult Services Coordinator

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

As designated above, the Division/AAA Liaison will be the primary point of contact for the AAA and:

- Coordinates call downs to AAAs within their regions.
- Compiles AAA's and aging network responses; and
- Report updates to the Lead Liaison.

Other Disaster Duties

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

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

Other Staff

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

IX. Emergency Operations Center

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

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

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

- Bring appropriate SERT identification to the EOC;
- Sign in at the front desk and again at the Human Services desk;
- Reference the Division/EOC notebooks and other materials situated at the Aging and Adult Services Desk - Human Services section as needed; and
- Brief incoming staff when shifts change about current situations and any unresolved issues.

Staff may call the representative at the EOC 919-825-2489 for updates, to report any news, or request assistance.

X. Coordination with Other DHHS Divisions

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

XI. Equipment and Supplies

One Disaster Notebook will always remain at the Division for in-house use during a disaster or for training purposes. This notebook will stay in the office of the Emergency Coordinating Officer. A second Disaster Notebook is kept at the Division of Aging and Adult Services desk at the EOC - Human Services Section. A third and fourth set will be kept at the home of the Emergency Coordinating Officer and the Disaster Preparedness and Recovery Coordinator.

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

XII. Training

A. Aging and Adult Services Networks

The Emergency Coordinating Officer will coordinate with the Disaster Team and key players such as AAA's and service providers to determine annual training needs and develop a plan for accomplishing training. She may also conduct or coordinate trainings outside the aging and adult services network regarding functional and access needs for older adults and people with disabilities.

B. The Division of Aging and Adult Services Staff

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

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

XIII. Sections

A. Adult Services

This Section manages the operation of programs providing services and benefits to older people and adults with disabilities primarily through the 100 County Departments of Social Services. These programs include adult protective services, guardianship, State/County Special Assistance for adult care homes and in-home, adult placement, at-risk case management, adult care home case management, and several counseling and case management services to support older people and adults with disabilities living at home. The Section uses both central office and field based representatives for consultation and oversight of county Departments of Social Services and other

participating providers. It also manages the Department of Health and Human Services Blanket Bond for guardianship and the Housing and Homelessness programs. This Section uses both central office and field representatives for consultation and oversight of these programs.

B. Planning, Information & Systems Support

This Section of the Division of Aging and Adult Services is responsible for the development of the State Aging Services Plan required by the NC General Assembly and the State's Title III plan required by the Older Americans Act. They are also responsible for reviewing and assisting the work of Area Agencies on Aging in implementing their area plans and for providing technical assistance to local service providers and others which includes support of local planning for the Home and Community Care Block Grant. The section is recently responsible for the Long Term Services and Supports initiative through Community Resource Connections (for Aging and Disabilities) whereby individuals of all disabilities and incomes have the opportunity to make informed, cost-effective choices regarding the services they may need. This may reduce inappropriate or premature institutionalization. The Section also serves as a vehicle for identifying, developing, analyzing and presenting information that instructs guides and supports the diverse work of the Division. Overall coordination of the Division's web site is also the responsibility of this Section.

This Section is also responsible for the development, operation and information systems for the NC Division of Aging and Adult Services. The section's work also involves management and maintenance of the Aging Resource Management Systems (ARMS), which is the Division's automated client tracking and reimbursement system. ARMS tracks clients and services, computes and triggers the reimbursement due to community service providers, and produces reports for use in program and fiscal management. In addition, this Section coordinates the Division's compliance monitoring functions.

C. Budget & Finance

The Budget Office provides oversight of the budget and finance for the NC Division of Aging and Adult Services. This includes budget preparation of appropriated and grant funding as well as the management of a funding plan for allocation of federal and state funds for use by the Division, Area Agencies on Aging, Counties and other contract vendors. The budget office is responsible for providing financial information for the division, department and Office of State Budget and Management as well as fiscal reporting for federal grant funds.

D. Elder Rights

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

E. Service Operations

This Section of the Division of Aging and Adult Services develops policies and procedures and oversees the operation of aging programs that focus on providing home and community services to older adults and/or their family caregivers. Program areas include in-home aide services, transportation, respite care, care management, information and referral, home health, adult day care and adult health, housing and home improvement, congregate nutrition, home delivered meals, and senior centers. This section has responsibility for state-required certification of Adult Day Care and Adult Day Health programs on an annual basis, along with voluntary certification of Senior Centers based on state standards. This Section is responsible for overseeing, developing, and carrying out activities relevant to Alzheimer's disease and caregiver support. The Section also oversees administration of the Title III-F Older Americans Act Health Promotion/Disease Prevention Program.

Pre Event: Call Down to AAA

Division/AAA Liaisons and Ombudsman Support Coordinator, advise AAAs:

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

- Activate your emergency plan (or monitor the situation and use your judgment about local conditions);
- Plan for a possible disruption in services;
- Make contact with local Emergency Management to coordinate activities;
- Make preparations to record needs and other statistical information from service providers to give as a daily report to the Division;
- Review the Post Event Call Down Report for pertinent information to be gathered;
- Begin call downs to key service providers. Advise them to:
  - activate emergency procedures;
  - prepare for potentially being shut down;
  - have key information with them;
  - coordinate with local emergency officials as needed;
  - begin call downs to at risk older adults to ensure they have someone to help them or essential needs can be met for a 72 hour period of time (water, food, heat/cool, light source, medications or other medical needs); and
  - maintain a log of requests, responses and referrals made and all unmet needs documented and reported to AAA daily or more often.

The Liaison should give a contact number and a designated time frame to gather daily information (next day, etc.) to report back.

Give AAAs emergency contact numbers of pertinent Division staff and EOC Human Services Section number (919-825-2489) for emergencies.

Post Event: Call Down Report from

Area Agencies on Aging

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

Q. NORTH CAROLINA AREA AGENCIES ON AGING (AAA) MAP

Area Agencies on Aging (AAA) are offices established through the Older Americans Act that facilitate and support programs addressing the needs of older adults in a defined geographic region and support investment in their talents and interests. In North Carolina AAAs are located within regional Councils of Government.

Area Agencies on Aging function in five basic areas:

- Advocacy
- Information brokerage
- Planning
- Funds administration quality assurance
- Program and resource development

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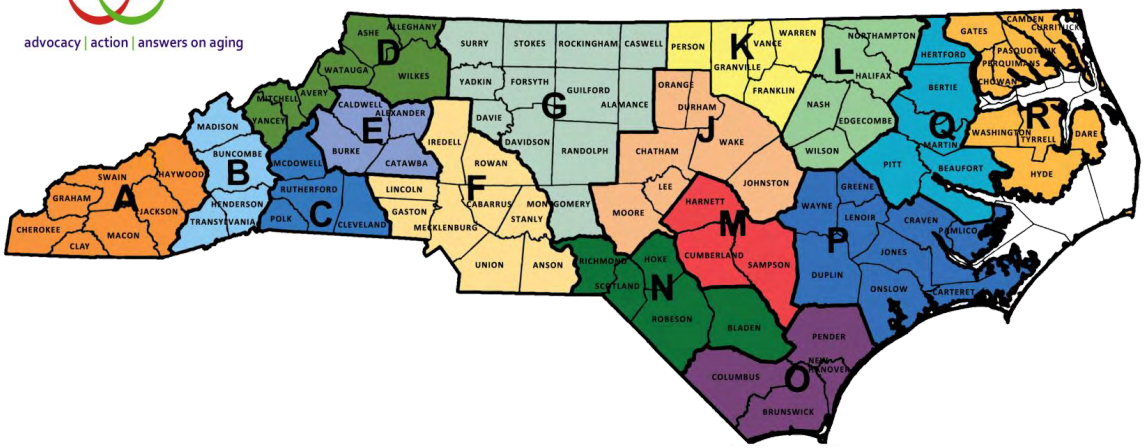
North Carolina Area Agencies on Aging



Region A – Southwestern Commission
Sarajane Melton, Area Agency on Aging Administrator
828-586-1962 x220, sarajane@regiona.org

Region B – Land of Sky Regional Council
LeeAnne Tucker, Area Agency on Aging Director
828-251-6622 x115, leeanne@landofsky.org

Region C – Isothermal Planning & Development Commission
Laura Lynch, Area Agency on Aging Director
828-351-2336, llynch@regionc.org

Region D – High Country Council of Governments
Zack Green, Area Agency on Aging Director
828-265-5434 x122, zgreen@hccog.org

Region E – Western Piedmont Council of Governments
Tina Miller, Area Agency on Aging Director
828-485-4212, tina.miller@wpcog.org

Region F – Centralina Council of Governments
Linda Miller, Aging Program Director
704-348-2712, lmiller@centralina.org

Region G – Piedmont Triad Regional Council
Adrienne Calhoun, Area Agency on Aging Director
336-904-0300, acalhoun@ptrc.org

Region J – Triangle J Council of Governments
Mary Warren, Area Agency on Aging Director
1-800-310-9777, mwarren@tjcog.org

Region K – Kerr-Tar Regional Council of Governments
Nancy Francis, Area Agency on Aging Director
252-436-2040 x2047, nfrancis@kerrtarcog.org

Region L – Upper Coastal Plains Council of Governments
Mary Marlin, Area Agency on Aging Program Director, 252-234-5956, mmarlin@ucpcog.org

Region M – Mid-Carolina Council of Governments
Tracy Honeycutt, Area Agency on Aging Director
910-323-4191 x27, thoneycutt@mccog.org

Region N – Lumber River Council of Governments
Twilla Allen, Aging Program Administrator
910-775-9781, tca@lrcog.org

Region O – Care Fear Council of Governments
Holly Pilson, Area Agency on Aging Director
910-395-4553 x209, hpilson@capefearcog.org

Region P – Eastern Carolina Council of Governments
Heather O'Connor, Human Services Director
252-638-3185 x3012, hoconnor@eccog.org

Region Q – Mid-East Commission
Annette Eubanks, Area Agency on Aging Director
252-974-1835, aeubanks@mideastcom.org

Region R – Albemarle Commission
Laura Alvarico, Area Agency on Aging Director
252-426-5753, lalvarico@accog.org

R. ACCOMPLISHMENTS OF THE 2019-2023 NC STATE PLAN ON AGING

GOAL 1: Safety and Protection

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

- Training and technical assistance to support the efforts of Area Agencies on Aging (training on APS) .
- Training curriculum on indicators of abuse, neglect and exploitation for healthcare providers, social services departments, and community-based organizations.
- Revised training curriculum on financial exploitation of seniors and other vulnerable adults.
- Communication distribution plan on abuse, neglect and exploitation for stakeholders through a brochure.
- Training for state hospital staff regarding alternatives to guardianship of adults with disabilities.
- Administration on Community Living ACL Voluntary APS Standards.

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

- Training curriculum to inform healthcare providers, social services departments, first responders and community-based organizations that teaches indicators of and responses to self-neglect.

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

- Building and fostering partnerships with legal service providers throughout the state to ensure underserved and underrepresented communities have access to information enabling them to make informed decisions through presentations and tracking the number of persons served.
- Support of the Rethinking Guardianship Initiative to improve NC's system of rights and protections for individuals who need support and assistance with decision-making.

GOAL 2: Quality and Life

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

- Analyze and assess current Home and Community Care Block Grant wait lists and utilize the Risk Assessment Tool as a means of determining an individual's greatest need (HCCBG Screening and Priority of Service Tool finalized).
- Support the operations of senior centers in the effective co-location of services, educational programs, wellness activities and evidence-based health promotion programs through technical assistance and training.
- Support programs that increase the availability of subsidized and moderate-income housing for seniors and those with disabilities by writing letters of support, assisting with grant applications, providing data, technical assistance and training (NC Housing Search).
- Increased participation in the Targeting Program among older and disabled adults through partnerships with a minimum of five new HCCBG-funded providers and/or local DSSs to promote success of aging populations moving into affordable housing (local DSS participated in trainings).

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

- Publicized the Senior Farmers' Market Nutrition Program (SFMNP) providing coupons and discounts to seniors that can be used to purchase fresh produce at local farmers' markets and achieved redemption rate of at least 80% annually.

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

- Address the issue and negative impacts of falls among older adults through a partnership with the North Carolina Falls Prevention Coalition to develop an updated, best practices fall prevention plan.
- Quarterly calls with AAA regional coordinators and partners to share best practices and strategize on ways to increase participation and program completion rates.
- Collaborate with the Institute of Medicine to implement a statewide task force that focuses on the social determinants of health known as "Healthy Aging to address issues and recommendations in the areas of falls prevention, food and nutrition security, mobility and transportation and aging in place (housing and shelter).

GOAL 3: Well Informed Communities

OBJECTIVE 3.1: Older adults and the community networks who serve them will be educated on the availability of services that foster independence, self-sufficiency, and enhance planning for long-term needs.

- Statewide outreach educational materials to educate the community and other service/healthcare providers (Brochure about statewide aging and adult services and support).
- Caregiver training and educational resources to caregivers to strengthen a family's capacity to provide care.
- Increase education and awareness of No Wrong Door/211 and how it can assist caregivers with respite resources, and access to long-term services and supports.
- Collaborate with NCCARE360 to increase referrals by the aging network to food, transportation, housing and personal safety resources.
- Educate older adults and community networks about an information and options counseling service designed to link people with available resources to meet their needs (Information and Options counseling page, options counseling workshop, information and options counseling PowerPoint).
- In partnership with the Department of Transportation (DOT), expand public awareness of driver safety resources and promote safe driving among older adults (NC Senior Driving website, National Highway Traffic Safety Administration's demonstration grant).
- Increase Medicaid administrative claiming and provide eligible individuals access to Medicaid treatment (MAC training).

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

- Increase the knowledge and skills of staff in the aging network to cultivate participant diversity (training dissemination, DAAS Equity/Inclusion Workgroup).
- Identify organizations that have dedicated holocaust survivor programs and disseminate information to the aging network (Distribute list of organizations with dedicated holocaust survivor programs to AAA).
- Through training, increase the awareness of professionals to work with the aging LGBTQ community in collaboration with Services and Advocacy for Gay Elders (SAGE). (training and educational webinars).

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

- Support public education and awareness of the needs of family. caregivers (recognize Governor's Proclamation of Family Caregiver Month and participate in Alzheimer's Awareness).
- Expand public awareness of caregiver resources, consultation and respite services through the aging network (Distribute resources).
- Educational and training materials for providers to help them direct caregivers to the most appropriate support services.
- Assess utilization of capacity of caregivers to use consumer direction via a survey of Lifespan Respite Voucher recipients.
- Educate county planning entities, AAAs and local service providers on consumer directed services (Educational meetings on Consumer Directed Services).
- Continue supporting implementation recommendations in the Strategic Plan for Addressing Alzheimer's Disease and Related Dementias to create a Dementia Friendly NC that supports caregivers (Created tool to document progress).

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

- Developed 2 marketing and training materials for use by senior centers to promote and educate individuals on their benefits.
- Support the Senior Center Alliance in the promotion and advocacy of senior centers.

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

- Completed goals set out in the Opioid Action Plan.
- Increase involvement and assist with the expansion of the "Lock Your Meds" campaign.

Goal 4: Strong and Seamless Continuum of Services

OBJECTIVE 4.1: NCDHHS, through the Division of Aging and Adult Services, will institute a multi-disciplinary advisory group that includes relevant divisions and strategic, system-level stakeholders to provide support and guidance on matters related to the aging community.

- Educate other divisions regarding programs available through DAAS and how the division may assist through partnering (presentations to various county departments of social services the role of guardians in the adult care home/nursing home transfer-discharge process).

OBJECTIVE 4.2: DAAS will improve performance-based outcomes for older adults by adopting an active contracts management framework to educate vendors and providers.

- Developing a plan to employ an active contracts management framework.
- Collaborate with contractors and vendors to develop performance measures that are measurable, achievable and reflect the needs of the people we serve.

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

- Develop a plan for dementia education and resource information to be included on the NCDHHS website (organized content for DAAS web page Dementia Education).
- Convene the Coalition for a Dementia-Capable NC to focus on furthering the recommendations included in the Dementia-Friendly NC plan.
- Provide leadership to a dementia-friendly communities workgroup for community leaders interested in beginning or growing a dementia-friendly community (hosted workgroups and held task force meetings).

- Inform AAA's, community networks and interested individuals on the Dementia-Friendly America (DFA) framework. (Distributed educational materials and presented).
- Coordinate with agencies and organizations that assist people with dementia and their caregivers to address common concerns (presentations).

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

- Establish quarterly task force meetings to develop recommendations for a workable plan of action during fiscal year 2019-2020. (Adult Services-Karey/Charles) (co-training with DMH/DD/SAS staff for Severe and Persistent Mental health training).
- Collaborate with the Institute of Medicine and other partners to issue a final report in 2020 with recommendations, including action steps.

S. DAAS BOOKLET: COMMUNITY RESOURCES AND CONNECTIONS

North Carolina
Division of Aging and Adult Services

COMMUNITY RESOURCES AND CONNECTIONS

Providing support to ensure the success of
North Carolina's aging population.

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Aging and
Adult Services

North Carolina's
AGING POPULATION

North Carolina ranks among the **top 10 nationally** for number of people **age 65 and over**.

1 in 5 NC residents will be older than 65 by 2025.

An estimated **1 out of every 4** adults age 65 and over live alone.

Despite growing life expectancy, **baby boomers experience high rates of heart disease, diabetes, arthritis, and obesity.**

Alzheimer's is the 4th leading cause of death in North Carolina among people 65 and over.

1 in 5 NC adults identify themselves as a caregiver; of these, 62% are caring for someone age 65 or older.

An Age of
OPPORTUNITY

As the older adult population in North Carolina increases, we are presented with new and unique opportunities. This rapid rise of older adults in the state's population has placed a greater demand on available funding and the work force. The increase also has affected resources such as community- based services and supports.

However, these challenges provide opportunities for innovative partnerships, collaboration, and dialogue to identify and address the needs of older adults and adults with disabilities and their caregivers.

Our Mission

The Division of Aging and Adult Services (DAAS) works to promote the independence and enhance the dignity of North Carolina's older adults, people with disabilities, and their families through a community-based system of opportunities, services, benefits, and protections.

Service Delivery System

DAAS relies on a solid network of partners, including 16 Area Agencies on Aging and 100 county Departments of Social Services, to connect with older adults, adults with disabilities, and their caregivers throughout the state.

- **Federal Government**
- **State Government**
  - 16 Area Agencies on Aging (AAAs)
    - Non-Profit Agencies
    - For-Profit Agencies
    - County Government Agencies
  - 100 County Governments
    - County Departments of Social Services (100)

DAAS Core Areas of Emphasis

ADVOCACY AND PROTECTION
Adult Protective Services, Adult Guardianship, Long Term Care Ombudsman Program

HOME AND COMMUNITY-BASED SERVICES
Health and Wellness Programs, Supportive Services, Family Caregiver Resources

ECONOMIC SUPPORTS
State/County Special Assistance, Special Assistance In-Home, Key Rental Assistance, SCSEP Program*, ESG Program*

*Senior Community Service Employment Program, Emergency Solutions Grant Program

Advocacy and Protection

Advocacy and protection programs inform individuals about their rights and how to address their concerns which allow them to protect themselves against exploitation, neglect, and abuse.

Adult Protective Services include evaluating the need for protective services and helping to secure food, safe housing, or medical care to remedy the problems that resulted in the abuse, neglect, or exploitation. ***North Carolina is a "mandatory reporter state",*** *which means that anyone suspecting mistreatment of an adult, of any age, with a disability needs to report their concerns to the DSS in the county where the person lives.*

The local DSS will:

- **Take the report**
- **Assure confidentiality**
- **Explains what happens once the report is taken**

Guardianship Services are provided to individuals alleged to be incompetent or determined to be incompetent by the county Clerk of Superior Court. DSS will:

- assess the need for guardianship
- help locate appropriate guardian(s)
- petition or assist the individual's family to petition for determination of incompetence and appointment of guardians
- provide ongoing support when the DSS director/assistant director has been appointed as guardian

Long Term Care Ombudsmen assist long term care residents by advocating to:

- ensure their ability to exercise their rights, receive quality care, and resolve complaints
- provide information to the public on long term care issues
- promote community involvement with residents and facilities
- assist providers with staff training

Economic Supports

Economic supports help ensure an individual's financial viability by supplementing discretionary income or by providing financial assistance for housing or shelter.

State/County Special Assistance provides a monthly financial supplement to eligible individuals to offset the cost of room and board in adult care homes/assisted living, family care homes, and group homes.

Special Assistance In-Home provides an alternative to placement in adult care homes for those who can live safely in the community with appropriate services. Payments assist with financial needs for health and safety related services.

Key Rental Assistance provides rental assistance to individuals with disabilities and a low income who occupy supportive housing units developed under the Targeted Housing Program.

Senior Community Service Employment Program is a workforce training program serving unemployed adults, age 55 and over, who live at or below 125% of federal poverty level.

Emergency Solutions Grant Program awards grants to homelessness service providers to offer street outreach, operate emergency shelters, and promote housing stability.

Home and Community-Based Services

Home and community-based services include a variety of health and human services delivered in the home or community to address social isolation and other social determinants of health and help people stay in their homes for as long as possible.

Health and Wellness Programs promote healthy aging and include services such as:

- community meal programs
- senior centers
- health and wellness classes that have been proven effective

Supportive Services include programs that allow individuals to remain independent such as:

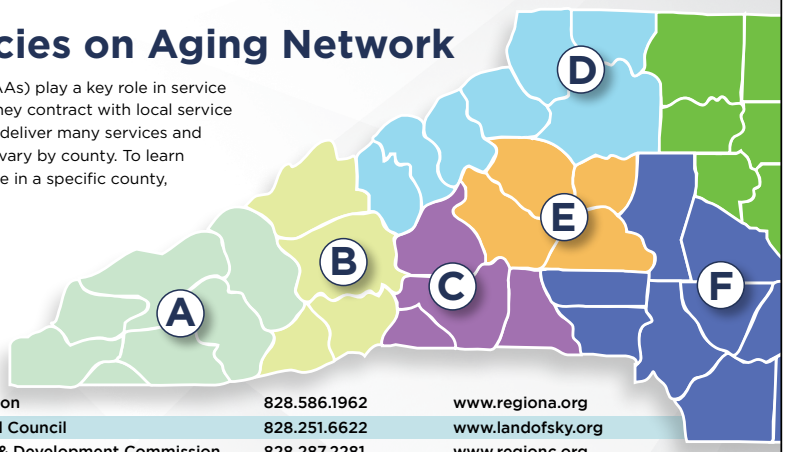
- home-delivered meals
- in-home aide assistance
- transportation
- legal aid
- home improvement
- resource navigation assistance

Family Caregiver Resources include an array of services to assist caregivers such as:

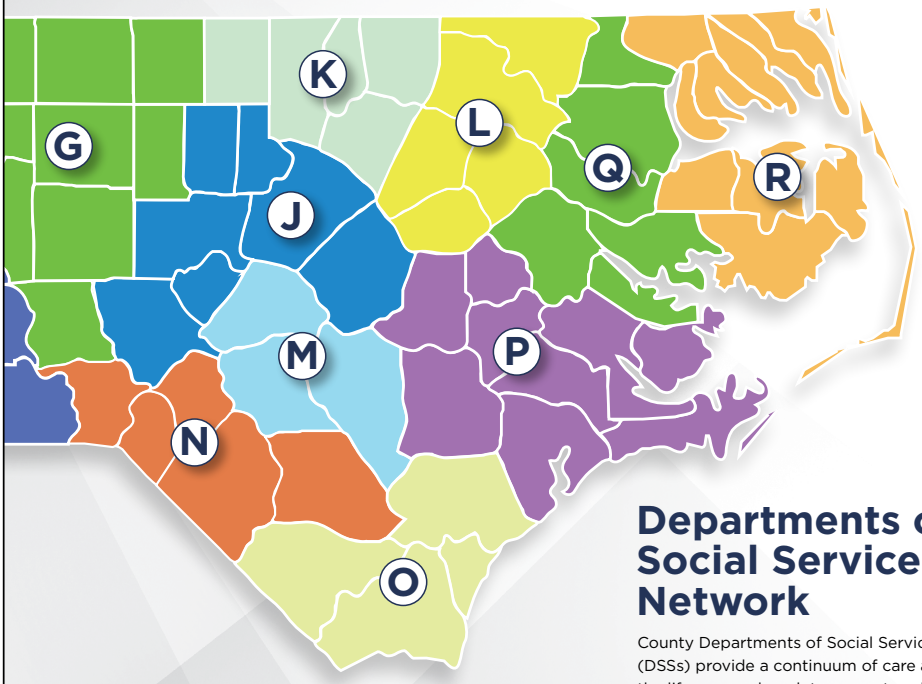
- information and referral
- training and counseling
- respite
- supports to keep individuals in the community

Area Agencies on Aging Network

Area Agencies on Aging (AAAs) play a key role in service coordination and delivery. They contract with local service providers to coordinate and deliver many services and supports. Available services vary by county. To learn more about services available in a specific county, contact the associated AAA.



A. Southwest Commission	828.586.1962	www.regiona.org
B. Land of Sky Regional Council	828.251.6622	www.landofsky.org
C. Isothermal Planning & Development Commission	828.287.2281	www.regionc.org
D. High Country Council of Governments	828.265.5434	www.regiond.org
E. Western Piedmont Council of Governments	828.322.9191	www.wpcog.org
F. Centralina Council of Governments	704.372.2416	www.centralina.org
G. Piedmont Triad Regional Council	336.904.0300	www.ptrc.org
J. Triangle J Council of Governments	919.558.2711	www.tjcog.org
K. Kerr-Tar Regional Council of Governments	252.436.2040	www.kerrtarcog.org
L. Upper Coastal Plain Council of Governments	252.234.5952	www.ucpcog.org
M. Mid-Carolina Council of Governments	910.323.4191	www.mccog.org
N. Lumber River Council of Governments	910.618.5533	www.lrcog.org
O. Cape Fear Council of Governments	910.395.4553	www.capefearcog.org
P. Eastern Carolina Council of Governments	252.638.3185	www.eccog.org
Q. Mid-East Commission	252.946.8043	www.mideastcom.org
R. Albemarle Commission	252.426.5753	www.albemarlecommission.org



Departments of Social Services Network

County Departments of Social Services (DSSs) provide a continuum of care across the lifespan and work to promote self-reliance and self-sufficiency and prevent abuse, neglect, and exploitation. To learn more about services available in a specific county, contact the county DSS.

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Aging and Adult Services

UNC
SCHOOL OF MEDICINE
Center for Aging and Health

Mailing Address: 2101 Mail Service Center, Raleigh, NC 27699 - 2101

Telephone: 919-855-3400 • www.ncdhhs.gov/assistance/aging-and-adult-services

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T. ACRONYMS, ABBREVIATIONS AND WEB RESOURCES

North Carolina State Government Offices and Agencies

- **DCR:** Department of Cultural Resources www.ncdcr.gov
- **DIT:** Department of Information Technology https://it.nc.gov
- **DMVA:** Department of Military and Veterans Affairs www.milvets.nc.gov
- **DOI:** Department of Insurance www.ncdoi.gov
- **DOJ:** Department of Justice https://ncdoj.gov
- **DOT:** Department of Transportation www.ncdot.gov
- **DAAS:** Division of Aging and Adult Services www.ncdhhs.gov/divisions/aging-and-adult-services
- **DCFW:** Division of Child and Family Well-being www.ncdhhs.gov/divisions/division-child-and-family-well-being
- **DHB:** Division of Health Benefits https://medicaid.ncdhhs.gov
- **DHSR:** Division of Health Service Regulation www.ncdhhs.gov/divisions/health-service-regulation
- **DMH/DD/SAS:** Division of Mental Health, Developmental Disabilities, and Substance Abuse Services www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse-services
- **DPH:** Division of Public Health www.dph.ncdhhs.gov
- **DSB:** Division of Services for the Blind www.ncdhhs.gov/divisions/services-blind
- **DSDHH:** Division of Services for the Deaf and Hard of Hearing www.ncdhhs.gov/divisions/services-deaf-and-hard-hearing
- **DSS:** Division of Social Services www.ncdhhs.gov/divisions/social-services
- **DVRS:** Division of Vocational Rehabilitation Services www.ncdhhs.gov/divisions/vocational-rehabilitation-services
- **NCBSE:** North Carolina Board of State Elections www.ncsbe.gov
- **NCCCS:** North Carolina Community College System www.nccommunitycolleges.edu
- **NCCDD:** North Carolina Council on Developmental Disabilities https://nccdd.org
- **NCCVCS:** North Carolina Commission on Volunteerism and Community Service www.nc.gov/working/volunteer-opportunities/volunteernc
- **NCDHHS:** North Carolina Department of Health and Human Services www.ncdhhs.org
- **NCHFA:** North Carolina Housing Finance Agency www.nchfa.com
- **Office of DEI:** Office of Diversity, Equity, and Inclusion of the NCDHHS Health Equity Portfolio www.ncdhhs.gov/about/administrative-offices/dhhs-human-resources/additional-hr-services/diversity-and-inclusion
- **OoC:** Office of Communications www.ncdhhs.gov/news/office-communications
- **ORH:** Office of Rural Health www.ncdhhs.gov/divisions/orh
- **OSHR:** Office of State Human Resources https://oshr.nc.gov

North Carolina Regional or County Government

- **AAA:** Area Agency on Aging www.ncdhhs.gov/divisions/aging-and-adult-services/adult-day-services/area-agencies-aging
- **LME/MCO:** Local Management Entity/Managed Care Organization, the regional organization that manages the delivery of public mental health services www.ncdhhs.gov/providers/lme-mco-directory
- **EBCI:** Eastern Band of Cherokee Indians https://ebci.com
- **NC ARCOG:** North Carolina Association of Regional Council of Governments www.ncarcog.com

Federal Government

- **ACL:** Administration for Community Living, U.S. Health and Human Services www.ada.gov
- **ADA:** Americans with Disabilities Act www.ada.gov
- **AOA:** Administration on Aging, U.S. Health and Human Services www.aoa.gov
- **ARPA:** American Rescue Plan Act www.whitehouse.gov/american-rescue-plan
- **CDC:** Centers for Disease Control and Prevention www.cdc.gov
- **CMS:** Centers for Medicare and Medicaid Services www.cms.gov
- **HHS:** U.S. Department of Health and Human Services www.hhs.gov
- **HUD:** U.S. Department of Housing and Urban Development www.hud.gov
- **IRS:** Internal Revenue Service www.irs.gov
- **OAA:** Federal Older Americans Act www.aoa.gov/aoaroot/aoa_programs/oaa/index.aspx
- **SAMHSA:** Substance Abuse and Mental Health Services Administration www.samhsa.gov
- **USDA:** U.S. Department of Agriculture www.usda.gov

Other Organizations and Partnerships

- **AARP NC:** AARP NC, the North Carolina chapter of AARP www.aarp.org/states/nc
- **CAA:** Carolina Aging Alliance www.carolinaaging.org
- **CCME:** Carolinas Center for Medical Excellence www.thecarolinascenter.org
- **CHCS:** Center for Health Care Strategies www.chcs.org
- **CWI:** Center for Workforce Inclusion www.centerforworkforceinclusion.org
- **FHLI:** Foundation for Health Leadership & Innovation https://foundationhli.org
- **FORLTC:** Friends of Residents in Long-term Care www.forltc.org
- **GAC:** Governor's Advisory Council on Aging www.ncdhhs.gov/aging/gaclist.htm
- **GAST:** Geriatric Adult Mental Health Specialty Teams www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/adult-mental-health-services/older-adult-mental-health
- **HANC:** Healthy Aging NC https://healthyagingnc.com
- **MOW:** Meals on Wheels North Carolina www.mowanc.org
- **NC4A:** North Carolina Association of Area Agencies on Aging www.nc4a.org
- **NCACDSS:** North Carolina Association of County Directors of Social Services www.ncacdss.org
- **NCALTCF:** North Carolina Association of Long-Term Care Facilities www.ncaltcf.com
- **NCANPHA:** North Carolina Association of Non-Profit Homes for the Aging www.ncanpha.org
- **NCAOA:** North Carolina Association on Aging www.ncaoa.org
- **NCBA:** National Caucus and Center on Black Aging https://ncba-aging.org
- **NCBAM:** North Carolina Baptist Aging Ministries www.ncbam.org
- **NCCCN:** North Carolina Community Care Network www.communitycarenc.com
- **NCCHW:** NC Center for Health and Wellness https://ncchw.unca.edu
- **NCCOA:** North Carolina Coalition on Aging https://nccoalitiononaging.org
- **NCFPC:** NC Falls Prevention Coalition https://ncfallsprevention.org
- **NCIOM:** North Carolina Institute of Medicine www.nciom.org
- **NCSDSC:** North Carolina Senior Driver Safety Coalition www.ncdot.org/doh/preconstruct/traffic/ECHS/groups/older.html
- **NCSG:** North Carolina Senior Games www.ncseniorgames.org
- **PK:** Public Knowledge https://pubknow.com

- **STHL:** North Carolina Senior Tar Heel Legislature www.ncdhhs.gov/aging/sthl.htm
- **UNC CARES:** Center for Aging Research and Educational Services, Jordan Institute for Families, School of Social Work, University of North Carolina at Chapel Hill https://cares.unc.edu

Grants, Projects and Programs

- **APS-R DPAG:** Adult Protective Services Register and Disinterested Public Agent Guardians
- **APS:** Adult Protective Services, Division of Aging and Adult Services www.ncdhhs.gov/aging/adultsvcs/afs_aps.htm
- **ARMS:** Aging Resources Management System, Division of Aging and Adult Services www.ncdhhs.gov/aging/arms/armsforms.htm
- **B.E. With and ASIST:** Belonging & Empathy With Intentional Targeted Helping and Applied Suicide Intervention Skills Training
- **BDT:** Benefits Data Trust https://bdtrust.org/nc-benefits-center
- **BOLD NC:** Building Our Largest Dementia Infrastructure www.cdc.gov/aging/bold/index.html
- **BRFSS:** Behavioral Risk Factor Surveillance System, Division of Public Health https://schs.dph.ncdhhs.gov/units/stat/brfss/
- **CAC:** Community Advisory Committee volunteer advocates appointed by county commissions who are part of the Long-Term Care Ombudsman Program www.ncdhhs.gov/aging/ombud/cac.htm
- **CAP-Choice:** Community Alternatives Program for Disabled Adults, consumer-directed option, Division of Health Benefits https://medicaid.ncdhhs.gov/capc
- **CAP-DA:** Community Alternatives Program for Disabled Adults, Division of Health Benefits https://medicaid.ncdhhs.gov/providers/programs-and-services/long-term-care/community-alternatives-program-disabled-adults-capda
- **CDSMP:** Chronic Disease Self-Management Program Grant—known in North Carolina as Living Healthy, Division of Aging and Adult Services www.ncdhhs.gov/aging/livinghealthy/livinghealthy.htm
- **CQI:** Continuous Quality Improvement
- **EBHP/DP:** Evidence-Based Health Promotion and Disease Prevention www.healthyagingprograms.org/content.asp?sectionid=32
- **EOC:** Emergency Operations Center
- **FCSP:** Family Caregiver Support Program, Division of Aging and Adult Services www.ncdhhs.gov/aging/fchome.htm
- **GPMS:** Grantee Performance Management System https://olderworkers.workforcegps.org/GPMS
- **HCCBG:** Home and Community Care Block Grant, Division of Aging and Adult Services www.ncdhhs.gov/aging/manual/hccbg/hccbg.htm
- **HCI:** Home Care Independence, Consumer-directed option through Home and Community Care Block Grant, Division of Aging and Adult Services www.ncdhhs.gov/aging/CDS/cds.htm
- **HHI:** Housing and Home Improvement www.ncdhhs.gov/divisions/aging-and-adult-services/housing-and-home-improvement-assistance
- **HMR:** Home Modifications and Repair www.ncdhhs.gov/divisions/aging-and-adult-services/housing-and-home-improvement-assistance
- **ILR:** Independent Living Rehabilitation, Division of Services for the Blind www.ncdhhs.gov/dsb/services/independent.htm
- **ILRP:** Independent Living Rehabilitation Program, Division of Vocational Rehabilitation www.ncdhhs.gov/dvrs/pwd/ils.htm
- **MDT:** Multidisciplinary Teams https://protectadults.sog.unc.edu/what-mdt
- **MFP:** Money Follows the Person, Division of Medical Assistance www.ncdhhs.gov/dma/MoneyFollows
- **MLTSS/LTSS:** Medicaid Long-Term Services and Support/Long-Term Services and Support https://medicaid.ncdhhs.gov/transformation/care-management/long-term-services-and-supports-care-management
- **MPA:** Multisector Plan for Aging www.chcs.org/resource/developing-a-master-plan-for-aging
- **NC ESG:** North Carolina Emergency Solutions Grant (NC ESG) www.ncdhhs.gov/divisions/aging-and-adult-services/nc-emergency-solutions-grant/nc-emergency-solutions-grant-grantee-information#:~:text=The%20Emergency%20Solutions%20Grants%20Program,house%20homeless%20individuals%20and%20families
- **NCATP:** North Carolina Assistive Technology Program, Division of Vocational Rehabilitation www.ncatp.org/index.htm

- **NCEM:** North Carolina Emergency Management www.ncdps.gov/our-organization/emergency-management
- **NCI AD:** National Core Indicators Aging and Disabilities https://nci-ad.org
- **NC SHIP:** North Carolina State Health Improvement Plan
- **NWD:** No Wrong Door https://nwd.acl.gov
- **PACE:** Programs of All-Inclusive Care for the Elderly, Division of Medical Assistance www.ncdhhs.gov/dma/services/pace.htm
- **Project CARE:** Caregiver Alternatives to Running on Empty, Division of Aging and Adult Services www.ncdhhs.gov/aging/ad/NCAlzDemo.htm
- **PSH:** Permanent Supportive Housing www.ncdhhs.gov/divisions/aging-and-adult-services/permanent-supportive-housing
- **SA-ACH:** Special Assistance Adult Care Home Program, Division of Aging and Adult Services www.ncdhhs.gov/aging/adultsvcs/afs_special.htm
- **SA-IH:** Special Assistance In-Home Program, Division of Aging and Adult Services www.ncdhhs.gov/aging/adultsvcs/afs_sa_inhome.htm
- **SAFE LTC:** Strategic Alliances for Elders in Long-Term Care, Division of Aging and Adult Services https://ltcombudsman.org/uploads/files/issues/KathrynLanierPPT.pdf
- **SAGE:** Advocacy and Services for LGBT Elders www.lgbtcenterofraleigh.com
- **SCSEP:** Senior Community Service Employment Program www.ncdhhs.gov/aging/scsep.htm
- **SERT:** State Emergency Response Team
- **SFMNP:** Seniors' Farmers Market Nutrition Program, Division of Aging and Adult Services www.ncdhhs.gov/divisions/aging-and-adult-services/north-carolina-seniors-farmers-market-nutrition-program-sfmnp
- **SHIIP:** Seniors' Health Insurance Information Program, Department of Insurance www.ncdoi.com/shiip/default.asp
- **SMP:** Senior Medicare Patrol, NC Department of Insurance www.ncdoi.com/SHIIP/SMP/shiip_smp_home.asp
- **SNAP:** Supplemental Nutrition Assistance Program
- **SSI:** Supplemental Security Income www.ssa.gov/ssi
- **TCL:** Transitions to Community Living www.ncdhhs.gov/about/department-initiatives/transitions-community-living

Other Acronyms

- **ARA:** Authorized Referral Agencies
- **CNA:** Certified Nursing Assistant/Nurse Aide https://info.ncdhhs.gov/dhsr/hcpr/curriculum/index.html
- **CMIST:** Communication, Maintaining Health, Independence, Support and Transportation
- **DEI:** Diversity, Equity, and Inclusion
- **EHR:** Electronic Health Records
- **FFY:** Federal Fiscal Year
- **IFF:** Intrastate Funding Formula
- **IDD:** Intellectual or Developmental Disability
- **LGBTQ+:** Lesbian, Gay, Bisexual, Transgender, Queer
- **MAAS:** Mobility as a Service
- **P&A:** Protection and Advocacy
- **PCA:** Personal Care Aide https://info.ncdhhs.gov/dhsr/acls/training/index.html
- **PDOH:** Personal Determinants of Health
- **SAC:** Stakeholder Advisory Committee
- **SMI/SPMI:** Severe mental illnesses/severe persistent mental illnesses www.ncdhhs.gov/about/department-initiatives/transitions-community-living
- **SOGI:** Sexual Orientation and Gender Identity
- **TBI:** Traumatic Brain Injury

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