Warmth in their Winter

WARMTH IN THEIR WINTER:

RECOMMENDATIONS TO HELP ELDERLY PEOPLE IN NEED IN NORTH CAROLINA

A REPORT OF A POLICY DEVELOPMENT CONFERENCE MARCH 1 and 2, 1988

Sponsored By

NORTH CAROLINA ASSOCIATION OF COUNTY DIRECTORS OF SOCIAL SERVICES

In Conjunction With

UNC-CH SCHOOL OF SOCIAL WORK PROGRAM ON AGING

FOREWORD

The North Carolina Association of County Directors of Social Services has produced a worthy follow-up to last year's recommendations on child poverty, this year choosing to focus on the needs of the elderly. Their new report, entitled "Warmth for their Winter," looks at the numerous problems which face the elderly in this state and proposes concrete solutions.

News reports constantly remind us of the aging of our society. People are living longer, so much longer, in fact, that by the year 2030 the number of those over 85 will have almost quadrupled. We can ignore these demographics only at our peril. An aging population will profoundly change the face of many of our institutions, particularly the social services.

Even more disturbing are the statistics which reveal the current extent of poverty and forced impoverishment among our elderly citizens. Today one in four elderly North Carolinians lives in poverty. And for those elderly persons who have resources, it only takes one period of institutional care to wipe out years of savings. This is today's intolerable situation.

These two separate conditions, important as they are alone, take on even greater significance together. Imagine the challenges we face as elderly needs and demographic growth combine in the years to come. What is today an oft unnoticed tragedy is shaping up to become a major national crisis.

This report outlines recommendations to begin to deal with these complex problems. Combining the practical knowledge of Social Services Directors from across the state with the expertise of researchers from a new Program on Aging at UNC, these proposals warrant our study. I invite you to read and ponder these recommendations and to begin thinking of your own experiences with the elderly.

Old age should be neither a time of want nor indignity. Yet for many North Carolinians, old age is just that. Let's begin to work seriously to solve these problems, both for today's elderly citizens and for the generations to come.

Willliam Friday
President Emeritus
University of North Carolina

INTRODUCTION

One year ago, the Association of County Directors of Social Services met together to discuss the distressing situation of many of North Carolina's families and children. The results of that meeting were the report "A Blueprint for the Future" and an advocacy effort aimed at improving the lives of poor families. Through that effort, we saw the benefit of an informed policy debate on social issues.

In 1988 we turn our focus to North Carolina's elderly people. Our elderly citizens face different yet equally devastating problems as do our poor families. Unlike our young families, most elderly people are not able to participate in the labor market. As these citizens grow older and lose most control over their incomes, adequate income supports become crucial to their well being. At the same time, the elderly often need expensive medical care, drugs, medical equipment, and long term care. With income dropping and expenses rising, our elderly citizens face a crunch. On top of this are the threats of exploitation and abuse, coupled with the stigma of being old in our youth-oriented society.

The societal response to these needs has been growing, yet is still inadequate. As our elderly population rapidly increases, staff, programs and funding will continue to lag behind the need. Currently, local Departments of Social Services expend 91 percent of the total state funding for social services for the elderly. Based on our large financial involvement with services for the elderly, it is particularly important for those of us in Social Services to evaluate the needs of the elderly in the future.

We in Social Services want to see continued, steady improvement in the condition of the elderly in this state. The recommendations of this report span the spectrum of problems which affect the elderly today. As with the "Blueprint" and the discussions it kindled, we hope this report can further the policy debate surrounding the needs of the elderly.

David A. Nolan
President
North Carolina Association
of County Directors
of Social Services

EXECUTIVE SUMMARY

The Association of County Directors of Social Services have formulated the following recommendations to address the growing needs of the elderly in North Carolina. As the number of elderly people in our state increases, we will face greater challenges than ever to provide for this group's needs. Ultimately, the state must move to eradicate poverty among our elderly people and to adequately serve and protect this often frail and vulnerable group of citizens.

The Association offers recommendations in six key areas:

Basic Needs

Through a variety of means, the state must assure that the elderly have adequate income to provide for their needs. A standard income support payment, based on need and indexed to inflation, could combine several program payments into one. This payment could assure that adequate income is available for food, housing, transportation, and medical needs. Punitive tax measures and program rules which force impoverishment must be eliminated. Finally, the state must encourage and fund outreach efforts to identify and help the poor elderly.

Health Care

The state must assure that the elderly are able to access the wide range of health services regardless of their ability to pay and without facing impoverishment. At the policy level, there is a critical need for improvements and expansions in Medicaid and Medicare coverage. Without additional funding for staff, local Departments of Social Services should become more involved in discharge planning and case management for the elderly. These staff could provide support to the elderly and their families and educate them about health issues.

Mental Health

In order to meet the mental health needs of our elderly population, increased coordination is required at the state and local levels. A model plan for geriatric mental health services should be implemented to create a continuum of mental health care. Additionally, training and advocacy efforts in the area of geriatric mental health need to be stepped up by state and local agencies.

Institutional Care

As with routine medical care, the greatest problem with long-term care for the needy elderly is the escalating cost. Programs must be designed to prevent the need for destitution of individuals before they can assess help with institutional care costs. At the same time, increased planning is needed to coordinate the care of the elderly as they move in and out of institutions. Finally, adequate and strictly enforced regulations are necessary to protect the elderly once they enter institutional care.

Protecting the Elderly

While great strides have been made in the prevention of abuse and neglect of the vulnerable elderly, improvements are still badly needed. State and local governments need to target resources to enhance public awareness of the problem of elderly abuse. Social service workers as well as other professionals should have opportunities to learn about elderly abuse. A review of protective service statutes is needed to suggest improvements in their content and clarity. Adequate funding is needed to expand quality protective services to all counties.

Staffing

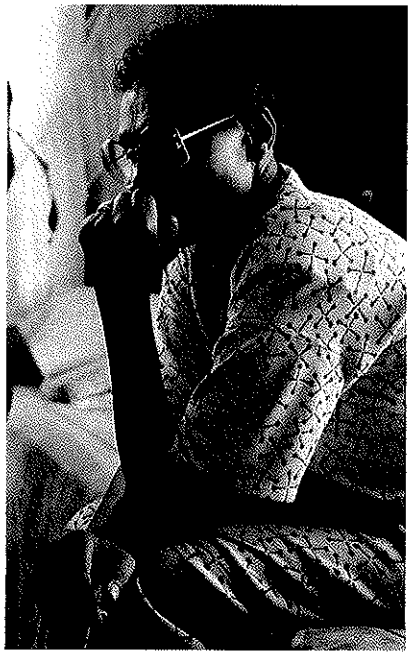
Sufficient, well-trained staff are needed to meet the increasing demands for services to the elderly. In order to attract and retain good quality workers, social work and eligibility staff must be placed at fair classification levels within the state system. Sufficient staff must be available to keep caseloads at appropriate levels, based on uniform state standards. Other areas of concern are the use of in-home workers and nurses, and the availability of training for all workers.

BASIC NEEDS

There exists no exact definition of poverty for North Carolina's elderly. Poverty can be assessed based on several factors; levels of income, assets, and/or amounts of government non-money benefits (such as Food Stamps) are useful measures.

In 1987, almost one out of four older North Carolinians had income at or below the federal poverty level, which for a single person was $5,500. This compares to national poverty rate of 14 percent for the elderly. Moreover, poverty rates are significantly worse among minority groups and in certain counties. The statewide poverty rate for black elders is twice that for whites, 41 percent versus 20 percent. Statewide, an alarming 52 percent of elderly black women living alone are below the poverty level. County poverty rates range to a high of 67 percent for black elderly in Hyde County and 41 percent for elderly whites in Ashe and Madison counties.

About 75 percent of North Carolina's elderly own their own homes. However, blacks and women without living spouses, are less likely to have this resource. For those without their own homes, the rise in rental prices around the state has had serious consequences. A recent survey estimated that 11 percent of the homeless were elderly. For all elderly citizens, housing quality is a concern. Twenty-five percent of the homes owned by the elderly belong to individuals who have difficulty making necessary repairs. Many elderly people live in substandard units, lacking adequate kitchens or plumbing. Over fifty percent of their homes lack air conditioning, while forty percent have no central heat.



While it has been difficult to obtain data about elderly participation in government benefit programs such as SSI, Food Stamps, Medicaid, employment programs, and housing, it is generally believed to be low. For example, national participation of the elderly in SSI is estimated at 55 percent, in North Carolina the participation rate is probably lower. Low participation rates in SSI and Food Stamps are linked to lack of public awareness, the stigma and fear associated with welfare agencies and previous turndowns. Low Medicaid participation is caused by the extremely low Medicaid income limit. Job and housing programs have the capacity to attract more elderly participation, but have been crippled by a lack of funding. In 1986, an estimated 48,000 elderly North Carolinians unsuccessfully sought low cost housing.

"The safety net is full of holes."

— The Villers Foundation

Meeting the basic needs of the elderly must become a top priority for our social services system. While poverty rates for the elderly remain high, leading to poor nutrition, housing and health care, our responses to the elderly are low benefit levels, a fragmented service delivery system, red tape and impoverishing regulations.

We recommend the following:

1. The state must base benefit payment levels on an established family living standard, which takes into consideration a family's actual needs and local variation in living costs.

2. Federal assistance programs used by the elderly (SSI, Energy Assistance, Food Stamps, housing, etc.) should be combined into one payment. There should be one application simplifying the system for clients. Administrative cost savings can be used to further benefit the elderly.

3. The Social Service system must implement a case management model for service delivery to the elderly. This will improve the coordination of services and increase service accessibility. At the same time, improved outreach efforts are needed to increase participation.

4. We must increase funding for in-home services and housing programs for the elderly.

5. We must work to educate all legislators and public officials about the needs of the low income elderly. This effort must include explaining the need for increased funding and for uniform service availability in all counties in the state.

6. We must maximize the indigenous resources within the elderly population in addressing the needs of the elderly. Additionally, we must encourage participation by churches, civic organizations and private industry in solving the problems of the elderly.

7. We must increase the personal exemption allowance for the elderly for state income tax purposes.

8. To improve the dignity of low income elderly people in long term care, we must increase the amount of personal needs money which elderly people in such care receive each month.

9. In order to aid our working elderly citizens, we must increase the amount of earnings which can be disregarded by Social Security recipients age 62 to 69.

HEALTH CARE

Two facts are converging in the area of health care for the elderly. First, the number of elderly people, especially those over 85, is increasing in North Carolina. Second, as people grow older, they become more prone to chronic health care problems and/or impairments. The results of this convergence have great implications for social and health policy in our state.

First, let's look at each of these facts separately. In the area of demographic change, the numbers are sobering. North Carolina has the eighth fastest growing elderly population in the nation.

North Carolina's growth rate (1980-2000) for citizens over 65 is 56% and 128% for those over 85.

The growth of the over 85 population is twice that of the "young old" population. In sheer numbers the over 85 group will increase from 45,000 in 1980 to 102,850 by the year 2000. As we move into the 21st Century, this trend will become even stronger.

Equally important are the statistics which point out the health needs of this population. Of those 85 and older, more than 60 percent have one or more functional impairments. Nearly one quarter have difficulties with three or more functional activities of daily living, such as dressing, bathing, toileting, walking, and getting out of bed. Almost sixty percent of those 85 and over receive assistance from another person, either an informal or formal service provider.

Putting these facts together, we can get an idea of the future medical needs of our elderly. Not surprisingly, we will be seeing dramatic increases in the need for this care. A study done by the Institute of Health and Aging at the University of California at San Francisco put North Carolina at the top of the list in anticipated need for additional care. The study, covering the years 1990-2000, revealed the statistics (lower left).

While the growing need for medical care services for the elderly is evident, access to needed services, particularly for the poor and near-poor, presents significant problems. In North Carolina, we can find elderly people who are uninsured, others who are underinsured, and a third group who face financial ruin due to medical bills. For the very poor, the Medicaid program provides resources for medical care. However, about 9

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Projected Increases in Elderly with Activity Limitations and Service Needs, 1990-2000

	National	N.C.
activity limitations	13%	20%
physician visits	10%	19%
hospital days of care	11%	24%
persons receiving home health	22%	34%
nursing home residents	27%	40%

percent of the poor elderly have incomes above the Medicaid limit. For those with more resources, the Medicare program provides protection. However, those who rely on Medicare, 71 percent of which are elderly, spend an average of $2700 a year in out of pocket medical expenses and report the highest rates of poor health and chronic disability of all the medically-indigent groups. Finally, nearly 300,000 individuals in our state, many of whom are low-income elderly citizens, spend over 20 percent of their annual income on medical expenses. The Catastrophic Protection Bill would correct this problem somewhat, but would not address the catastrophic costs of long term care.

We believe that our rapidly expanding aging population should have access to the full range of health care necessary to maintain, enhance and promote their physical and mental well-being. This range of care should include dental, preventive and primary health care, ophthalmology, audiology, pharmaceutical, in-home services, home health services, adult day care, domicillary care and nursing home care.

We recommend the following:

1. The system should expand Medicaid coverage to elderly people with incomes less than 100% of the poverty level, rather than the current 75% figure.

2. We should simplify the Medicaid eligibility process, by eliminating excessive regulations and paperwork, making access for the elderly less of an ordeal. Funding for adequate eligibility staff is needed to assure the elderly prompt, accurate and considerate service.

3. Medicaid regulations which create spousal impoverishment should be changed. The same budgeting practice used for institutionalized elderly should be used for those at home to prevent impoverishment and inadvertent encouragement of institutionalization. A short-term measure would be to mandate MA-CAP to all 100 counties.

4. Medicare, which currently pays for only 40% of care received, must be expanded to fill the gaps in coverage, such as dental care, pharmaceuticals, and preventive care. The two year waiting period for disabled pre-65 persons to receive Medicare must be shortened.

5. Federal legislation is needed to expand Medicare coverage to provide long term care so that elderly people do not need to impoverish themselves to become eligible for Medicaid.

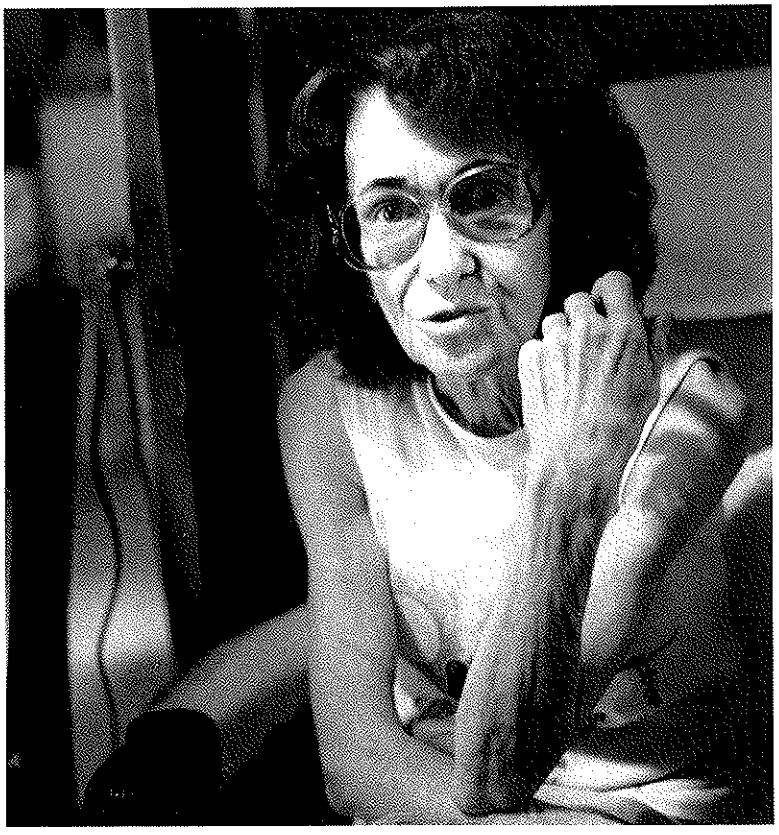
6. We must increase the avenues of service provision for low income elderly persons. Through advocacy and a simplified reimbursement procedure, we must see that all physicians and other medical care givers will accept Medicaid and Medicare patients. Additionally, funding should be made available to support in-home long-term care services. Finally, physical and geographic barriers must be eliminated through the availability of transportation and escort services.

7. We support expanded efforts to provide needed medications to the elderly. We need to expand Medicare coverage for medications, create bulk buying arrangements with hospitals and health departments, encourage use of generic drugs, and establish a state program to monitor the availability of certain drugs.

8. We must support and educate the elderly and their family networks through a variety of creative means. Respite care for families deserves increased funding. Tax breaks should be provided to families who care for an ill elderly person at home. Education about fraudulent insurance and drug use should be expanded.

MENTAL HEALTH

The two most commonly encountered mental health problems among the elderly are impaired mental functioning and depression. These mental health problems add additional strains to the elderly's already limited resources and create additional difficulties in arranging services and placement for the elderly.



A recent study in five North Carolina counties by Duke University reveals some important findings about the mental health needs of the elderly. Although the study did not find an increase in the prevalence of mental disorders among the elderly as compared to the non-elderly, it did discover the disturbing fact that a majority of elderly people experiencing mental health problems do not obtain mental health services.

Impaired mental functioning does increase with age. For example, over 40 percent of the persons over age 85 in the Duke study had some degree of cognitive impairment. Research has shown that such impairment is a major stress for caregivers and often leads to institutionalization. When these impaired elderly citizens are institutionalized, it has been found to be expensive, labor-intensive and stressful to both staff and residents.

"A majority of elderly people experiencing mental health problems do not obtain mental health services."

With reference to in-patient mental health services, the elderly resident population in state hospitals has increased from 23 to 27 percent over the last five years. Upon discharge, many of these individuals are placed in domiciliary care facilities. A recent study of a Durham family care home found that 73 percent of the residents had mild to severe mental impairment, with 20 percent experiencing severe mental impairment.

Depression is the second major mental health problem of the elderly. It is difficult to determine the extent of this problem because of the difficulty in its diagnosis. The depression of the elderly can be related to the grieving of lost loved ones, displacement or worry about financial problems. Studies show that the majority of the elderly with depression receive no care.

Access to mental health services for the elderly remains a problem. Eighty percent of the elderly still do not access out-patient mental health services. The elderly are, in fact, more likely to seek these services from general medical providers than from mental health professionals. The elderly also often ask for help from in-home service workers who are typically not trained to provide mental health services.

The elderly and their families have the same need for access to the mental health system as do all other populations in our society. Mental health services should provide approriate levels of prevention and treatment, thus developing a continuum of services for all elderly persons.

We recommend the following:

1. An increased level of planning and coordination is urgently needed to aid access to mental health services for the elderly. The N.C. Department of Human Resources should provide leadership in modeling state level coordination and planning on mental health issues. At the same time, a model plan for geriatric mental health services should be implemented at the local level. This model plan would include well-trained staff to offer a variety of much needed services. These services would include outreach, in-home screening, advocacy work and work with adult day care centers and domiciliary facilities.

2. The Division of Mental Health should define specific services for the elderly. The Division of Social Services should specify gaps in current mental health services which prevent or delay the DSS's ability to carry out its mandated services.

3. State mental hospitals need to respond cooperatively to the needs and plans of local mental health and social service workers. All hospitals should institute discharge planning for elderly mental patients. This would insure that no patient is discharged without an adequate and appropriate plan.

4. Department of Human Resources agencies need to step up their advocacy efforts for the devalued elderly. These elderly include the poor, sick and disabled, the demented and Alzheimers patients.

5. Training should be required for the following staff in specified skill areas: for mental health and DSS staff in geriatrics and interdisciplinary work, for DSS staff in preparation of mental status assessments and general clinical social work training.

6. A decision should be made on whether Alzheimers disease is to be treated primarily in the mental health system or as a medical problem by the health system.

INSTITUTIONAL CARE

Institutional care represents one end of the long term care continuum. It is the most restrictive alternative for the elderly. Long term care comes in two common forms: nursing homes, providing a high-level of care, and so-called domiciliary care facilities, which offer less intensive care. The chart below gives an overview of the long term care population in North Carolina in 1986.

Institutional care can also refer to care provided in state mental facilities. The Division of Mental Health, Mental Retardation and Substance Abuse services thirteen state facilities which serve elderly individuals. Finally, the term "institutional" should also refer to the back-up of clients in acute care hospitals and those who are awaiting nursing home or community placement.

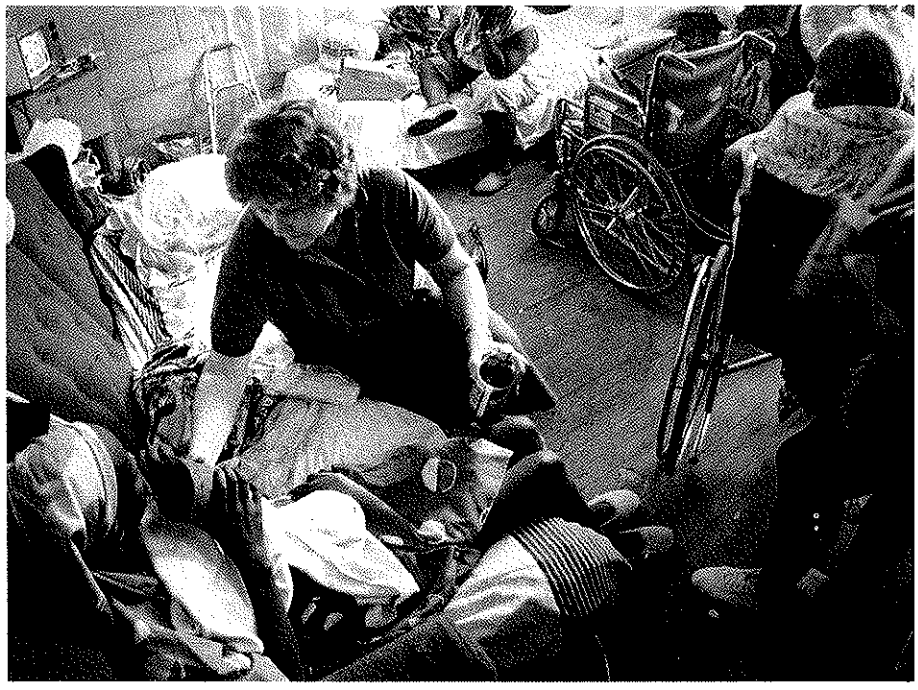
Such back-ups may be a result of shortages of nursing home beds or the desire of hospitals, particularly in rural areas, to keep patients longer than their conditions justify.

One key issue in institutional care is the question of which type of care is appropriate in a given case. Because of the perception that nursing home care and domiciliary home care overlap, older adults are often mismatched in placement. Unfortunately, the easy availability of a bed may determine the placement regardless of appropriate care needs.

Type of facility	Number of beds
skilled nursing facilities	*10,477*
intermediate care facilities	*10,766*
total nursing home beds	*21,213*
homes for the aged	*15,203*
family care homes	*3,201*
total domicilary care beds	*18,404*
Grand Total	***39,617***

Another issue is the amount of responsibility departments of social services should have over clients in long term care facilities. At present, it is unclear what role should be played in placement and on-going case management with nursing home clients. Because of Medicaid, there is a strong case for increased DSS involvement in nursing home care. With domiciliary care clients, the questions are more urgent. While the evidence is scattered, we do know that a significant percentage of domiciliary clients are chronically mentally impaired and that others are in need of medical care which these facilities are not licensed, staffed or trained to perform.

"The easy availability of a bed may determine the placement regardless of appropriate care needs."



North Carolina must directly face the issues surrounding the placement of family members in long term care facilities. The rapidly expanding aging population coupled with the problems of cost, access and the quality of care demand a thoughtful and timely response.

We recommend the following:

1. In order to create a continuum of care within each county, we recommend that each county board of social services develop a continuum of care plan for that county on an annual basis. This plan would cover the spectrum of services ranging from in-home services to long term care facilities. The plan would recommend appropriate state funding for its implementation.

2. The state must ensure appropriate planning for long term care. This is imperative to prevent nursing home bed shortages and to maintain appropriate levels of care. We recommend that the state, providers, counties, and consumer representatives engage in a cooperative effort to determine appropriate levels of need for long term care services. This effort would be focused upon the results being included in the state medical facilities plan.

3. The long term care placement process must be made more effective. Improvements should include effective standardized assessment, increased coordination among all parties involved and more attention to special needs patients. The case management model of service is the most effective means of serving these clients.

4. We must assure that financial considerations do not prevent our elderly citizens from receiving quality long term care. Medicaid patients should have the same right to access long term care beds as do private pay patients. We must change regulations which force elderly citizens into destitution in order to be eligible for services. Additionally creative funding mechanisms and insurance plans need to be developed to handle the growing cost of long term care.

5. We recommend increased vigilance in the timely and consistent enforcement of long term care standards and laws. The Directors Association has already adopted recommendations to improve such enforcement: Technical assistance should be provided to long term care operators as appropriate.

6. We recommend that the County Directors Association establish a standing committee composed of appropriate associations, including consumer representation, aimed at establishing a partnership and formal communications structure between these organizations.