Community Needs Assessment of the Aging Population

Prepared by UNC Charlotte Urban Institute
December 2014
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Acknowledgements

This report was prepared by Elyse Hamilton-Childres in fulfillment of her Master of Social Work internship at the UNC Charlotte Urban Institute. The project was completed on a pro bono basis for the Charlotte-Mecklenburg Council on Aging and the local aging services network as a whole. The UNCC Urban Institute accepts responsibility for the research and findings. All photos in this report come from the U.S. Census Bureau, Public Information Office.

About the Authors

Dr. Bill McCoy served as the primary supervisor for this project. Dr. McCoy served as director of the UNC Charlotte Urban Institute from 1985 to 2001. He has been active in the Mecklenburg community for more than 40 years, holds various leadership roles in the local aging services network, and served as Chair of the Board of the Charlotte-Mecklenburg Council on Aging. For this project, Dr. McCoy oversaw the research process, facilitated interviews and focus groups, and contributed to analysis of findings, development of recommendations, and editing of the report.

Social Research Intern Elyse Hamilton-Childres was the primary researcher. She completed this project as part of her Master of Social Work curriculum at the University of North Carolina at Chapel Hill. Elyse coordinated and conducted interviews and focus groups, collected and analyzed data, and wrote the report.

Social Research Specialist Claire Apaliski had a key role in supervising the primary researcher, assisting with data collection and analysis, and editing the report.

Linda Jacobs Shipley, Senior Associate Director, provided additional supervisory support and assisted with editing the report.

Many community members and professionals within the local aging services network participated in interviews and focus groups. The Board of Directors of the Charlotte-Mecklenburg Council on Aging was engaged throughout the project.
About the Sponsoring Organizations

Charlotte-Mecklenburg Council on Aging

The Charlotte-Mecklenburg Council on Aging (CMCOA) began in 1979 as an education and advocacy-focused organization for older adults in Mecklenburg County. Since that time, the CMCOA has initiated and collaborated on numerous projects to carry out its mission of transforming the Charlotte-Mecklenburg area into a senior-friendly community. Activities of the CMCOA have centered on systems-level planning, education, and advocacy related to senior housing, caregiving, transportation, emergency management, information and communications, and other pressing issues.

The UNC Charlotte Urban Institute

The UNC Charlotte Urban Institute was established in 1969 as a non-profit, non-partisan applied research and community outreach center at the University of North Carolina at Charlotte. The UNCC Urban Institute provides services including technical assistance and training in operations and data management, public opinion surveys, and research and analysis around economic, environmental, and social issues affecting the Charlotte region. For more information, visit http://ui.uncc.edu/.
The UNC Charlotte Urban Institute conducted this study on the needs of the aging population in order to benefit the Charlotte-Mecklenburg Council on Aging (CMCOA), the local aging services network, and the community as a whole.

The primary purpose of the project was to generate an update on the most pressing needs of the aging population in Mecklenburg County.

A secondary function was to explore programmatic and funding trends among organizations with a focus on education and advocacy for older adults.
Background & Methods

In 2012, residents age 65 and older numbered 90,685 and accounted for 9% of the total population in Mecklenburg County.\(^1\) By 2030, that percentage will increase to 15% of the total population as the number soars to 204,653.\(^2\) In light of the impending demographic shift, this study identifies unmet needs of those age 50 and older in Mecklenburg County and develops recommendations for addressing needs at the local level. The rationale for assessing the age 50 and over population is to examine the needs of current older adults (i.e. people age 65 and older) along with the baby boomers who will become the next generation of older adults. Cross-generational analysis allows for discussion about how the needs of boomers may be similar or different from the needs of current older adults.

This study applied a mixed methods approach including the reviews of previous community assessments, secondary data analysis, key informant interviews, and focus groups. Based on the needs identified through these sources, a set of community recommendations on how to improve the quality of life for the local aging population was developed.

Key needs fall within three categories:
- Housing and Accessibility
- Health and Wellness
- Education and Advocacy

In order to inform the practices of the Charlotte-Mecklenburg Council on Aging (CMCOA) and other organizations committed to systemic education and advocacy for older adults, a comparative analysis of Councils on Aging in North Carolina and various aging service organizations throughout the U.S. was conducted. The findings of the comparative analysis led to a set of programmatic and funding recommendations for education and advocacy-focused organizations such as the CMCOA.
Key Community Needs

From the review of previous community assessments, examination of secondary data, and analysis of feedback from key informant interviews and focus groups, three categories of need emerged among older adults and boomers in Mecklenburg County: Housing and Accessibility, Health and Wellness, and Education and Advocacy. Overall, current needs are similar to those identified in past needs assessments. The following figures detail key needs within each category.

Housing and Accessibility Needs

• Support services, housing options, and accessible designs that promote aging in place
• Age-friendly affordable housing for low- and middle-income older adults
• Accessible and flexible transportation, particularly for those who no longer drive

Health and Wellness Needs

• Specialized, affordable, and accessible geriatric health and mental health care
• Affordable and accessible caregiver support services, especially respite
• Expanded opportunities for social engagement for those at risk of isolation

Education and Advocacy Needs

• Accessible and accurate information on what resources are available for older adults
• Systematic community education on aging issues
• Expanded lifelong learning opportunities for older adults
• Recognizable spokesperson and/or go-to organization for aging issues
• Targeted advocacy for vulnerable groups within the older adult population
Key Community Recommendations

Systemic causes of unmet needs include a lack of preparation and planning for the growth of the aging population, inadequate communication and collaboration between various groups, and the centralization of resources in Charlotte. The following recommendations call for improving the status of older adults and boomers in Mecklenburg County by addressing these fundamental challenges.

Create Long-Term Solutions

Systematic planning and preparation for the growth of the aging population are critical. It is recommended that Mecklenburg County revive the Status of Seniors Initiative (SOSI) described in Appendix A and leverage its wealth of information to develop an effective county-wide aging plan. Additional recommended long-term solutions within each category of need include:

**HOUSING AND ACCESSIBILITY**
- Local planners and leaders can establish policies that promote aging in place such as the inclusion of universal design and visitability standards in zoning ordinances, location of affordable and accessible housing along transit lines, and the adoption of best practices for street safety and design.

**HEALTH AND WELLNESS**
- Community leaders can campaign to attract physicians who specialize in geriatric health care and to reinstate a geriatric psychiatric unit.
- Employers can review workplace policies to ensure they are friendly and flexible for working caregivers.
- Health care leaders and employers can adopt policies requiring all health providers who serve older adults to receive training on geriatric health and mental health care.

**EDUCATION AND ADVOCACY**
- The local aging network can designate one organization or person to serve as the “go-to” voice for aging issues in Mecklenburg County.
- Local leaders can prioritize aging issues in agendas and budgets.
- Service providers can develop systematic campaigns to educate older adults about how to access existing resources.
- Employers can establish policies that promote education for all employees on planning and preparing for retirement.
- Service providers and community members can campaign to educate the public about issues impacting the aging population as a whole as well as vulnerable sub-populations such as elderly immigrants.
Key Community Recommendations

Coordinate to Cover Gaps in Services

Fragmented systems and services are a pervasive challenge in Mecklenburg County. Inadequate coordination between non-profits, for-profits, public service organizations, faith communities, and consumers prevent the area’s wealth of resources from reaching their full potential. Greater collaboration is needed to increase the impact of positive change initiatives and to close gaps in services as quickly and cost-effectively as possible. The following figures detail some methods for increasing coordination and collaboration in each of the three areas of need:

**HOUSING AND ACCESSIBILITY**

- Providers can collaborate to establish consistent housing and transportation eligibility requirements and to expand transportation options for those living in the suburbs and those with low incomes.
- Community members can organize to develop Villages, co-housing communities, or other supportive housing models that promote aging in place by increasing access to and affordability of services such as household repair, transportation, and health care.

**HEALTH AND WELLNESS**

- Health care providers can work together to develop consistent age cut-offs and eligibility requirements and to expand health care options for low- and middle-income residents.
- Service providers in all sectors (for-profit, non-profit, public, and faith-based) can collaborate to expand caregiver support for vulnerable older adults through strategies such as subsidized placements or sliding fee scales.
- Caregivers can mobilize to create avenues for mutual support and advocacy including peer support groups, forums, or social clubs.

**EDUCATION AND ADVOCACY**

- Local leaders can coordinate opportunities for older adults to participate in decision-making through councils or other avenues.
- Providers can market services through existing information hubs such as Just1Call, All About Seniors, and Senior Grapevine. Providers can commit to keeping this information up-to-date.
- Community members can organize peer support groups or forums to share feedback related to locating and securing resources.
- Community members can organize and engage in grassroots advocacy through actions such as letter-writing campaigns, phone calls and meetings with elected officials, petitioning, and voting.
Key Community Recommendations

Decentralize Resources
The centralization of resources in Charlotte is a barrier for those living in outlying suburbs. There is a need for existing resources to be available throughout the county. It is essential to promote the delivery of services and activities directly into neighborhoods where people live, rather than requiring people to come to providers for assistance. The following figures highlight recommendations for decentralizing resources within each area of need:

**HOUSING AND ACCESSIBILITY**
- Providers can organize to implement service delivery models such as Naturally Occurring Retirement Community Supportive Service Programs (NORC-SSPs). NORC-SSPs bring resources such as home repairs, transportation, health care, and socialization programs directly into residential areas with high concentrations of older adults.

**HEALTH AND WELLNESS**
- Service providers can collaborate to deliver health and caregiver support services directly into communities with large concentrations of older adults, thereby increasing access to care.
- Service providers can work together to coordinate and disseminate diverse social activities across the county at different times and locations, targeting boomers as well as older adults.
- Community members can organize neighborhood groups to check on elderly residents and coordinate neighborhood social events.

**EDUCATION AND ADVOCACY**
- Providers can coordinate to implement a county-wide no-wrong-door, single-access approach to finding and securing resources and services, including follow-up to ensure those seeking help receive assistance.
- Providers can bring information and educational programs directly into places with large concentrations of older adults, including long-term care facilities, neighborhoods, and churches.
- Providers can distribute resource information county-wide in multiple formats (e.g., electronic, hard copy, auditory, visual), at an accessible comprehension level, and in different languages.
Key Comparative Analysis Findings
Several trends emerged from exploration of the activities and revenue sources of twenty Councils on Aging (COAs) in North Carolina and twelve nonprofits throughout the U.S. with a focus on education and advocacy for older adults:

- The vast majority of the Councils on Aging included in this study operate as direct service providers. Systemic education and advocacy are generally not prominent COA activities.

- Council on Aging revenues are derived from multiple sources and reflect the emphasis on direct service provision. The most significant revenue sources include government grants, program service contracts and fees, and other contributions, gifts, and grants.

- Numerous Councils on Aging are rebranding and restructuring.

- The majority of the education and advocacy-focused nonprofits included in this study provide direct services in conjunction with systems-level education and advocacy.

- Advocacy activities of education and advocacy-focused organizations target specific issues impacting older adults.

- Revenue sources of education and advocacy-focused organizations are diverse and reflect the variety of services and activities provided. The most significant revenue sources include fundraising proceeds, program service contracts and fees, government grants, and other contributions, gifts, and grants.
Key Recommendations for Education and Advocacy-Focused Organizations

Based on the comparative analysis findings, it is recommended that the Charlotte-Mecklenburg Council on Aging (CMCOA) and other organizations dedicated to systemic education and advocacy for older adults consider the following practices:

INTEGRATE DIRECT AND SYSTEMIC INTERVENTIONS
Few organizations are able to survive solely on a mission of systems-level education and advocacy. Organizations that supplement systemic education and advocacy with direct services seem to be more sustainable, as they are eligible for a wider range of funding sources.

DIVERSIFY REVENUE STREAMS
Most aging service organizations included in this study rely on a variety of funding sources including government grants, program service revenue, fundraising events, investment income, and other contributions, gifts, and grants. Diversification of funding sources is integral to surviving in a tough economy.

BRAND AND MARKET
Many Councils on Aging in North Carolina are rebranding, restructuring, and moving away from the generic Council on Aging title. Education and advocacy-focused organizations throughout the U.S. display a variety of unique brands. By adopting a brand that creatively and accurately captures the organizational mission, aging service organizations can seize an opportunity to market to the community and attract potential donors and consumers.
Introduction

This report presents the findings and recommendations of a needs assessment of Mecklenburg County’s aging population. The study aims to benefit the Charlotte-Mecklenburg Council on Aging (CMCOA), the local aging network, and others in the community with an interest in making Mecklenburg County a more livable place for people of all ages. The body of the report contains two parts. Part One details key needs of local older adults along with accompanying recommendations for addressing the identified needs. Part Two highlights programmatic and funding trends arising from comparative analysis of numerous Councils on Aging and nonprofits with a focus on education and advocacy for older adults. The resulting recommendations focus on approaches for increasing the sustainability of education and advocacy-focused organizations such as the CMCOA.

Nearly a decade has passed since the last county-wide study of older adults, the Status of Seniors Initiative, was undertaken. Within that time, demographics have changed. The first of the substantial baby boom generation born between 1946 and 1964 reached the traditional retirement age of 65 in 2011. Over the next decade, about 8,000 boomers will turn 65 every day in the U.S.³ This diverse generation is driving unprecedented growth of the older population across the globe.

Mecklenburg County is no exception to these changes. It is now more important than ever to understand the needs of current older adults and aging boomers in order to plan and prepare effectively for this important segment of the local population. The following sections outline contextual factors framing the needs presented in this report.
Demographic Context
The number of older adults is increasing worldwide due to increasing life expectancy, declining birth rates, medical advances, and the aging of the baby boomers. The population of Mecklenburg County has been growing older and younger at the same time due to aging of established residents along with an influx of younger new residents. Between now and 2030, however, those age 65 and older will increase at a faster percentage rate than the general population. A primary challenge over the next few decades will be designing strategies that not only meet the needs of older adults and boomers but are also nimble enough to adapt to the remarkable diversity within these groups.

Economic and Political Context
The economic downturn of the past several years has negatively impacted the aging population. Older adult programs have fallen prey to widespread budget cuts, resulting in reduced services and longer wait lists for basic assistance such as transportation, meals, and in-home aid. At the same time, individual financial assets have frequently declined and poverty rates have risen among boomers and older adults. During the worst of the recession, unemployment rates rose as many older adults re-entered the labor force. In Mecklenburg County, these trends have occurred within an environment of diffuse leadership. The absence of a recognized voice for the aging population has left older adults especially vulnerable to the destructive recessionary tide.

Promising Developments
Interest in aging issues seems to be rising among some local funders and leaders, and innovations are occurring within the aging network. For example, AARP now has a base in Charlotte, Senior Centers will soon merge with Parks and Recreation, and interventions such as the Program of All-Inclusive Care for the Elderly (PACE) and the Centralina Council of Governments’ Volunteer Transportation Program are occurring to meet the needs of vulnerable residents and help people age in place. In light of developments such as these, there is hope that a leader will emerge to mobilize the community around the aging population and advocate for Mecklenburg County to prepare for its growth.
The primary objectives of this study are to generate an update on the most pressing needs of the aging population in Mecklenburg County, to explore programmatic and funding practices related to education and advocacy for older adults, and to propose recommendations for how the Charlotte-Mecklenburg Council on Aging (CMCOA), aging network, and greater community can better serve older adults. The study used a mixed methods approach to achieve these objectives, including review of prior needs assessments, secondary data analysis, key informant interviews, focus groups, and comparative analysis of various aging service organizations.

Qualitative data including feedback received during key informant interviews and focus groups added depth to trends identified in secondary data. Both the quantitative and qualitative data suggest the current needs of older adults are similar to those identified in past needs assessments. Comparative analysis of Councils on Aging as well as education and advocacy-focused organizations provided a context in which to evaluate the mission and activities of the CMCOA. The following sections detail these research methods.
Review of Prior Research
The study began with a review of previous community assessments focusing on older adults in Mecklenburg County. Needs identified in the past served as a baseline for determining how the status of local older adults may have changed or stayed the same over time. The studies reviewed were completed in the past decade. Appendix A presents a summary of prior research.

Secondary Data Analysis
In order to create a demographic profile of older adults in Mecklenburg County, data from secondary sources were collected at the county level. Sources include federal, state, and local agencies such as the U.S. Census Bureau, North Carolina State Center for Health Statistics, and the Charlotte Housing Authority.

When possible, longitudinal data were compiled to examine change over time. Indicators were analyzed by age to highlight differences between current older adults (age 65 and older) and baby boomers (ages 50-64).

Key Informant Interviews
To enrich the information acquired from the review of prior research and secondary data sources, twenty-one interviews were conducted with individuals who are or were active in the aging services network in Mecklenburg County.

The participants included direct aging service providers, current and former local government leaders, professors, board members of the Charlotte-Mecklenburg Council on Aging, and current and former leaders of aging and social service organizations. Most were white, male, and between the ages of 55 and 84.

Interviews were semi-structured and lasted 1-2 hours. All participants were asked three primary questions. Outside of the three questions, the interviews were flexible, and variations occurred in conversation. This flexibility allowed the researchers to tailor additional questions according to the expertise of the interviewee. Appendix B includes a copy of the interview guide and a list of participants.

Transcripts from the interviews were analyzed by identifying major themes and sub-themes that were aggregated and examined for outstanding patterns. The most
frequently identified needs, strengths, and recommendations arising from these patterns constituted the findings for this part of the study.

Focus Groups
Following completion of the majority of stakeholder interviews, the next phase of the study was the coordination and facilitation of ten focus groups. The purpose of the focus groups was to gather information about the needs of older adults from a cross-section of community members, primarily older adults. Community members were recruited through existing organizations within the aging services network, and 94 individuals participated. Although an effort was made to gather a diverse group of participants, most were white, between the ages of 55 and 84, and female.

Each focus group lasted 60-75 minutes and took place at a location familiar to the participants, usually on site at each aging service organization. Similar to the key informant interviews, the discussion was semi-structured. While each group was asked similar questions, variation was permitted in the exact wording of each question from group to group. This flexibility allowed tailoring of the questions according to whether a group represented seniors, caregivers, or service providers. See Appendix C for copies of the focus group discussion guides.

Transcripts from the focus groups were analyzed by identifying major themes and sub-themes that were examined for outstanding patterns. The most frequently identified needs, strengths, and recommendations constituted the findings for this part of the study.

Comparative Analysis
One of the compelling reasons for undertaking this study was to inform the Charlotte-Mecklenburg Council on Aging (CMCOA) about how it might better serve the community. To accomplish this objective, the CMCOA’s activities were compared with the activities of twenty other Councils on Aging in North Carolina and twelve organizations across the U.S. with a focus on systemic education and advocacy for older adults. These organizations were identified primarily through a combination of websites: The North Carolina Division of Aging and Adult Services, GuideStar, Google, county government websites, and organizational websites. The goal of the comparative analysis was to identify promising programmatic and funding practices. Findings are applicable not only to the CMCOA but also to other organizations with an interest in education and advocacy for older adults.
No single data source can tell the full story of the aging population. When viewed as a whole, however, previous needs assessments, secondary data, interview responses, and focus group feedback form a rich picture of the challenges and opportunities surrounding older adults in Mecklenburg County. In order to offer this rich perspective to readers, the data and findings are presented in three broad categories of needs facing older adults: Housing and Accessibility, Health and Wellness, and Education and Advocacy.

Attention to strengths is woven throughout the discussion of needs. Participants in focus groups and interviews pointed out positive characteristics of the aging population and the greater Mecklenburg community. Experience, knowledge, free time, desire to give back, and financial assets were the most frequently identified strengths of older adults. The diverse array of existing resources and people stood out as the most valuable quality of the county as a whole.

These strengths are incorporated into identification of opportunities for change within the three major categories of need. They also inform the final recommendations, which call for building upon existing resources to create efficient and cost-effective solutions to pressing problems.
Profile of Older Adults in Mecklenburg County

The demographic profile in the following sections and figures describes basic characteristics of the aging population in Mecklenburg County including size, racial and ethnic composition, gender, educational attainment, socioeconomic status, and labor force participation.

Population Growth

The older adult population in Mecklenburg County has grown substantially in recent years. Between 2002 and 2012, the number of residents ages 50-64 increased 58%, from 103,687 to 163,547. During the same time, those age 65 and older increased 47%. It is important to acknowledge, however, that the Mecklenburg County population as a whole has become simultaneously older and younger. As a percentage of the total county population, 50-64 year-olds gradually expanded from 14.1% in 2002 to 16.9% in 2012, and the 65 and older age group grew slightly from 8.4% in 2002 to 9.4% in 2012 (Figure 1).

Major demographic change is just around the corner. By the year 2030, the 50-64 age group is projected to double to 246,113, representing 18.2% of the total county population. The most significant transformation will occur among those age 65 and older. This population is projected to skyrocket 125% to 204,653, accounting for 15.1% of the county population by 2030 (Figure 2).
Altogether, residents age 50 and over comprised about a quarter of the county population in 2012. By 2030, one-third of the population will be age 50 and older. Several factors account for this shift, including the aging of the baby boomers, rising life expectancy, and declining birth rates.\textsuperscript{12}

Those age 65 and older live throughout the county but are somewhat more concentrated around the perimeter (Figure 3). Most social/human services and cultural activities are located in Charlotte. This centralization is a barrier to service delivery and social engagement for the large numbers of older adults residing in the suburban towns of Cornelius, Davidson, Huntersville, Matthews, Mint Hill, and Pineville.

**Gender**

The older adult population has a greater percentage of females than males, in part because females have a longer life expectancy.\textsuperscript{13} In 2012, 59\% of those age 65 and older in Mecklenburg County were female, and 41\% were male (Figure 4).\textsuperscript{14}
Race and Ethnicity
From 2002 to 2012, the 50-64 and 65 and older age groups experienced similar changes in racial and ethnic composition. The percent of White residents decreased, while the percent of minority groups increased, most notably the Black/African American, Hispanic, and Asian populations (Figures 5-8). Though both age groups became significantly more diverse over the ten-year time span, diversity among those ages 50-64 increased to a greater extent. As the population ages, this rapid pace of diversification will carry over into the 65 and older age group.

Figure 5. Population Ages 50-64 by Race/Ethnicity, 2002
Source: US Census Bureau, Population Estimates

Figure 6. Population Ages 50-64 by Race/Ethnicity, 2012
Source: US Census Bureau, Population Estimates

Figure 7. Population Age 65 and Older by Race/Ethnicity, 2002
Source: US Census Bureau, Population Estimates

Figure 8. Population Age 65 and Older by Race/Ethnicity, 2012
Source: US Census Bureau, Population Estimates
Educational Attainment

Examining educational attainment by age reveals marked differences. In 2012, 10% of the population ages 45-64 did not have a high school diploma (Figure 9). That proportion increases to 15% for those age 65 and older. In addition, a greater percentage of 45-64 year-olds received a higher education. Nearly half (47%) earned an Associate’s, Bachelor’s, graduate or professional degree compared with 36% of those 65 and older.16

The 45-64 population as a whole has more formal education than those 65 and older. Those 65 and older tend to have lower educational attainment, and a greater percentage have less than a high school education. One factor contributing to this trend is that manufacturing and agriculture, two primary pursuits in decades past, did not require completion of high school. Disparities in educational attainment are important for several reasons. Those who did not finish high school are more likely to experience literacy barriers, poverty, and negative health outcomes. In contrast, higher education is correlated with higher incomes and better health outcomes. The next generation of older adults is expected to be healthier and to live longer than the current generation. However, the negative effects of the Great Recession on individuals’ finances and overall quality of life could offset some of the positive effects of one’s higher educational attainment.
Household Income

Householders ages 45-64 tend to have higher incomes than householders age 65 and older, in part because those ages 45-64 are not yet at retirement age and are more likely to be in the workforce. In 2012, 54% of Mecklenburg County householders ages 45-64 earned $60,000 or more, compared with just 35% of householders age 65 and over. On the opposite end of the income spectrum, 18% of those ages 45-64 earned less than $25,000, in contrast with 30% of individuals age 65 and older (Figure 10).17

Poverty

Between 2008 and 2012, the percent of residents ages 45-54, 55-64, and 65 and older living in poverty increased (Figure 11). The poverty rate increased the most among 55-64 year-olds and the least among those age 65 and over.18 Throughout the Great Recession, the financial status of the 65 and older population likely remained more stable than other generations due to reliance on Social Security Income. Many baby boomers had no such safety net to fall back on. The recession’s impact on boomers will continue to play out as the population ages and copes with effects of depleted savings accounts, unemployment, underemployment, and reduced financial resources.
Unemployment and Labor Force Participation

The unemployment rate also reflects the impact of the Great Recession. Between 2008 and 2012, unemployment rates across all age groups (45-54, 55-64, 65 and older) increased and peaked in 2010 (Figure 12). Since that time, unemployment rates among all groups have gradually fallen but are still above the 2008 levels where the recession began. Unemployment for the 65 and older population reflects the percentage of older adults who are still part of the labor force but are unable to find work.19

Examining the number of individuals in the labor force reveals that the 65 and older population was the only one of the three age groups with a positive percent change between 2008 and 2012 (Figure 13). The percent of residents ages 45-54 and 55-64 in the labor force decreased by 0.6%. The percent of people age 65 and older in the labor force increased by 30%; however, this age group accounts for a significantly smaller proportion of the labor force than younger generations.20

The increase in workers age 65 and older is likely an indication of individuals retiring later or pursuing new careers after retirement. Older adults may remain in or re-enter the workforce due to financial concerns and/or the desire to stay socially engaged.
Housing and accessibility needs emerged as the most pressing concern of boomers and older adults in this study. Challenges such as aging-friendly infrastructure, affordable living options, and transportation surfaced in every interview and focus group. These matters have also received the most attention in past needs assessments.

The following sections elaborate upon three major housing and accessibility issues:

- Aging in place
- Affordable housing
- Transportation
Aging in Place

Aging in place is simply living in one’s home and/or community for as long as possible instead of moving somewhere else to meet the changing needs that come along with advancing years. The act of aging in place, however, is not so simple. Aging in place is a complex and multifaceted issue requiring not only innovative housing solutions, but also coordination across sectors from land use and transit to health and human services. Mecklenburg County has abundant opportunity to develop vibrant communities that allow people to age in place, yet most of this opportunity is untapped. The following points summarize strengths and weaknesses related to aging in place.

Current Strengths and Needs Status

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<tr>
<th>Strengths</th>
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<tr>
<td>❖ Aging in place has numerous economic, health, and social benefits for individuals and communities such as cost savings when compared with residing in a long-term care facility, increased life expectancy, and reduced social isolation.</td>
<td>❖ Additional long-term care supports and services are needed to help older adults age in place.</td>
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<td>❖ Mecklenburg County has resource-rich areas that are ripe for aging in place, including neighborhoods surrounding colleges/universities and small, tightly knit communities such as Davidson.</td>
<td>❖ Existing long-term care supports and services in Mecklenburg County need to be more affordable for middle-income adults who do not qualify for public assistance, and also more accessible to those living in the suburbs.</td>
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<td>❖ Mecklenburg County has the potential for innovative community-based housing such as Villages and Naturally Occurring Retirement Community Supportive Service Programs.</td>
<td>❖ Accessible housing and community design needs to be a priority.</td>
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Findings
Research on the costs and benefits of aging in place is limited, but what is available is promising. Aging in place may be the most affordable housing choice for people who own their homes and no longer have mortgage payments, who can access their home equity as income, or who are likely to have difficulty selling their homes. Aging in place may also be the more affordable long-term care option. In 2009 dollars, the average monthly cost for long-term care services in U.S. communities was $928 per person compared with $5,243 for those in facilities such as nursing homes. Even for people needing help with activities of daily living (ADLs) such as bathing and dressing, the cost of care was on average about two times less in communities versus facilities.

Preliminary evidence links aging in place with improved social outcomes such as reduced social isolation and increased civic engagement, which in turn lead to better health outcomes. Many people involved in aging in place programs show improved physical function, fewer symptoms of depression and pain, improved cognitive function, and increased life expectancy.

Benefits from aging in place do not stop with the individual; they are also likely to reach local businesses and governments. While more research is needed in this area, it stands to reason that if residents age in place, the financial and human capital they bring to a community also stays in place. Most residents who remain in their homes continue to pay taxes. Many older adults launch second or third careers after retirement, leading to new jobs and services for the community. The prevalence of these “encore careers” is predicted to increase as more retirees seek ways to contribute to the community. A 2011 Encore.org and MetLife Foundation study found that one in four Americans ages 44-70 were thinking about starting their own businesses or nonprofits within the next few years. The Kauffman Index of Entrepreneurial Activity identified the 55-64 year-old cohort as the age group with the fastest growing number of entrepreneurs.

The very steps required to prepare a community for aging in place are likely to boost the local economy. An initiative to make existing and new homes, buildings, infrastructure, and services accessible and aging-friendly can spur more jobs. These actions may also enhance a community’s marketability to new retirees and caregivers seeking an aging-friendly environment. Businesses catering to the older population (e.g., long-term care,
insurance companies, wealth managers, estate attorneys, private medical care companies) may also be attracted to a community that promotes aging in place.

It is important to note that aging in place is not possible for everyone, nor is it what everyone wants. However, research has consistently found that most people want to stay in their current homes and/or communities as they grow older. In Mecklenburg County, the 2010 UNC Charlotte Urban Institute Annual Survey found that 88.6% of respondents age 65 and older and 74.4% of respondents ages 45-54 thought that as they aged, staying in their homes as long as possible would be the best housing situation. Surveys sponsored by the Charlotte-Mecklenburg Council on Aging Housing Task Force and the Davidson Aging in Place Task force documented similar findings in 2009 and 2008, respectively.

The vast majority of older adults in Mecklenburg County are currently aging in the community, not in long-term care facilities. In 2012, 96% of those age 65 and older were living in households, while only 4% lived in group quarters (Figure 14). This trend changed very little between 2008 and 2012. Living in a household includes living alone, with family, or with nonrelatives. Living in group quarters includes but is not limited to residing in a nursing home or another type of long-term health care facility.

Just because most older adults are already aging in place does not mean they are enjoying the full benefits of aging in place. Participants in this study indicated a need for greater support for those living in the community.

For example, aging in place requires affordable and accessible long-term services and supports. Participants communicated the perception that high-income people can for the most part meet their own needs, low-income people can frequently qualify for services, but people in the middle fall through the cracks. Neither qualifying for public assistance nor having sufficient means of their own, too often they are forced to forego care or spend down their assets on long-term care costs.
Participants expressed concern about the impact of reduced financial resources, rising health care costs, and the dwindling pool of family caregivers on residents’ ability to secure the supports required for aging in place.

An independent living difficulty is one indicator of a resident’s need for assistance in order to continue to age in place. From 2008 to 2012, the percent of residents age 65 and older with an independent living difficulty remained steady at around 15% (Figure 15).29 As baby boomers age, this percentage is likely to increase.

The geographic size of Mecklenburg County presents an additional obstacle to implementing long-term care services and supports. In general, research participants who live in Charlotte and near the county’s urban core identified fewer gaps in services than those who live in the suburbs. Central-living residents perceived Mecklenburg County as relatively rich in resources. The main problem they identified was the fragmentation and lack of coordination among existing services, which also plague outlying towns.

Going forward, a solution is needed to circulate and coordinate long-term services and supports throughout the county. It is also essential for those in the suburbs to feel acknowledged and connected to the larger Charlotte community, not ignored and isolated.

Aging in place requires home and community environments that are flexible with individuals’ changing needs. One way to build flexibility into the environment is by incorporating principles of universal design and visitability. Universal design is about planning spaces and products to be safe, accessible, and usable for people of all ages, abilities, and backgrounds.30 Safety refers both to the physical safety of a place as well as emotional or psychological safety. Universal design reduces stigma by integrating
accessibility features so that they are seamless and beneficial to anyone, thereby promoting inclusion and equality.\(^{31}\)

Universally designed public spaces may feature automatic sliding doors, large print on packaging and signs, or clearly marked pedestrian and bike crossings to reduce risk of injury and make it easier for anyone to come and go. Housing design may showcase reinforced walls to allow future installation of grab bars, wider doorways and hallways, curbless showers, or lever handles instead of round knobs. Regardless of what goes into it, the point of universal design is, "... when done well, it is invisible."\(^{32}\) For older adults, universal design holds particular significance. An inclusive, accessible environment can mean the difference between social engagement and isolation, wellness and illness, and high or low quality of life. Universal design also helps diminish ageism, or discrimination because of age.\(^{33}\)

Visitability is a more limited approach compared with universal design. It covers many of the same features that allow people to come and go with ease (e.g. step-less entryways, wide doorways, lever handles, first floor bathrooms), but they may be more obvious than in universal design. Carolyn Cook, an interior designer in Mecklenburg County, describes visitability as "... an affordable, sustainable and inclusive design approach for integrating basic accessibility features into all newly built homes and housing."\(^{34}\) Adopting universal design and/or visitability standards in Mecklenburg would benefit older adults, people with disabilities, families with children, and others. It may also benefit builders, who will face increasing demand for accessible environments as the older population grows, and it would increase the marketability of Mecklenburg as a cutting-edge community for people of all ages.
Community Feedback
Focus group and interview participants voiced several concerns related to aging in place in Mecklenburg County. The aging in place concerns include:

- The need for more services to allow people to age in place, such as in-home aid and assistance with household repairs
- The need for aging in place to be integrated within existing communities so that it does not become a way to isolate people by age
- The need for creating community-based alternatives for people living in facilities who prefer to be in the community
- The need for a greater variety of options for aging in place, especially for low- and middle-income older adults
- The need for a way to find trustworthy people to help around the house with tasks such as repairs, landscaping, and cleaning
- The need for more affordable in-home aid options for those who do not qualify due to financial or eligibility barriers
- The need for more care/case management services
- The need for existing and new housing to be accessible to older adults and people with disabilities or mobility challenges
- The need for greater accessibility within the broader community environment, including but not limited to wider sidewalks, more sidewalks, more bike paths, safer bike lanes, completed greenways, larger wording on street signs, clearly marked crosswalks, and better lighting on streets

Strategies for Positive Change
There are several ways in which residents, service providers, and community leaders can collaborate to promote aging in place. These strategies include:

- Community members can organize to develop supportive housing communities such as Villages.

In short, a Village is a grassroots approach to aging in place that involves residents forming an entity (usually a nonprofit) to connect them with discounted and vetted services in the community. These services allow residents to stay in their homes for as long as possible. Transportation, household repairs, lawn care, fitness activities, health care, and social events are common services delivered to Village residents. Mecklenburg County does not yet have any Villages of this kind, although some residents of Davidson are exploring the possibility of creating one.
Unlike Villages, Naturally Occurring Retirement Communities (NORCs) come into being without planning. A NORC is a neighborhood, building, or community that happens to have a large concentration of older adults. Because NORCs have many older adults in one place, they provide a unique opportunity for providers to deliver efficient and cost-effective services. Local organizations from various sectors can collaborate to deliver long-term care services and supports directly into existing NORCs. Common NORC-SSP services include transportation, health care, education, home repairs, and social activities. Mecklenburg County does not have any NORC-SSPs at this time.

Aging in place communities can be developed in existing resource-rich areas to increase access to services and activities. Resource-rich areas have amenities such as grocery stores, pharmacies, and medical facilities within walking distance. Neighborhoods surrounding universities and colleges are examples of resource-rich areas in Mecklenburg County.

Planners can provide incentives for developers to bring amenities such as grocery stores and health care facilities into resource-poor areas in order to increase opportunity for more residents to age in place.

Planners can adopt universal design and/or visitability standards in zoning ordinances and/or offer incentives for developers to use these principles.
Affordable Housing

Affordable housing is related to aging in place, but it is also a need that stands alone. When many people think of affordable housing, the image that comes to mind is one of struggling families with young children. In fact, affordable housing is a critical need for all individuals throughout the life course. Those who live in homes they cannot afford may be compelled to make difficult spending choices, live in substandard and unsafe housing, or become homeless. Increasingly, affordable housing is a concern not only for low-income residents, but also for the middle class. This study reinforced past research showing affordable housing as an area of growing need among older adults in Mecklenburg County. The following list highlights opportunities and challenges.

Current Strengths and Needs Status

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<tr>
<td>Mecklenburg County has some affordable housing for older adults through organizations such as the Charlotte Housing Authority, Salvation Army, and The Housing Partnership.</td>
<td>The need for affordable housing is especially acute among middle-income older adults who cannot afford expensive retirement communities but do not qualify for housing assistance.</td>
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<tr>
<td>Minor home repair services are available to some residents through organizations such as Love, Inc. and Shepherd’s Center.</td>
<td>Those who live in older homes face additional barriers to affordable housing, such as the need for home repairs and renovations to aid aging in place and ensure safety.</td>
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<tr>
<td>Mecklenburg County has the potential for developing Villages and Naturally Occurring Retirement Community Supportive Service Programs, which can connect residents with discounted home repairs, renovations, and other services.</td>
<td>There is a shortage of affordable housing that is accessible for older adults and people with disabilities.</td>
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Findings
This report defines affordable housing based on a household spending no more than 30% of its annual income on renting or home owning.\textsuperscript{38}

As others have observed,\textsuperscript{39} the current affordable housing supply in Mecklenburg cannot keep up with demand. Indicators of demand include housing cost burden, affordable housing wait lists, and homelessness.

A significant percent of householders age 65 and older are cost-burdened, meaning they spend more than 30% of their annual income on costs related to renting or home owning. In 2012, 30% of homeowners age 65 and older were cost-burdened and living in unaffordable housing. This trend remained relatively stable from 2008 to 2012 (Figure 16).\textsuperscript{40}

Figure 16. Selected Monthly Owner Costs as a Percentage of Household Income in the Past 12 Months for Homeowners Age 65 and Older, 2008-2012
Source: US Census Bureau, American Community Survey 1-Year Estimates

The rate of housing cost burden is higher among renters. In 2012, 57% of renters age 65 and older spent 30% or more of their income on gross rent. The percent of renters age 65 and older who are cost-burdened and living in unaffordable housing grew steadily from 2008 to 2011 and declined in 2012 (Figure 17).\textsuperscript{41}
Wait lists for affordable low- and moderate-income housing through the Charlotte Housing Authority (CHA) have increased. As of April 2014, 328 people ages 55-64 and 113 people ages 65 and older were on the CHA wait list for public housing. In addition to lower out-of-pocket utility costs, public housing offers efficiency and one-bedroom homes that may better suit the downsizing needs of older adults.

The fact that the number of residents aged 55-64 on the public housing wait list in April 2014 was nearly three times the number of residents age 65 and older indicates high demand for affordable housing among the next generation of older adults. This demand is alarming in the context of decreasing affordable housing supply, economic uncertainty, and reduced individual financial resources. Risk of hardship may be especially great for middle class older adults who do not qualify for subsidized housing and do not have the means to afford an expensive retirement community or extensive household repairs.

Data on homelessness in Mecklenburg County also suggests high demand for affordable housing among baby boomers. Out of the 165 unsheltered homeless individuals interviewed during the 2014 Point-in-Time Count on a single night in January, 59 people (36%) were between the ages of 50 and 64. Only 4 individuals (2%) were age 65 or older. Part of the reason for this discrepancy is the shortened life expectancy of homeless individuals. Another reason may be the inability of existing resources to meet the housing needs of the large baby boomer population.

Among those who have housing, many face the challenge of maintaining their homes. In this study, a commonly cited barrier was the difficulty of getting help with household repairs and maintenance. Over and over again, older adults said their homes were in need of repairs, but they were unable to find affordable and reliable assistance. Those who had applied for help through local churches or service organizations reported mixed results; some received the help they needed, while others did not.

Developing more avenues for older adults to access vetted home repair services is critical for aging in place and also for maintaining the value of existing housing stock. The need for these services is particularly acute among residents living in older homes.
In 2012, 83% of homeowners age 65 and older in Mecklenburg County were living in homes built in 1999 or earlier (Figure 18). These structures are more likely than newer homes to be in need of repairs and lacking accessibility features.

Another barrier to keeping existing homes affordable is a lack of visitable and/or universal design. When housing is not designed with accessibility in mind, it often becomes prohibitively expensive for low- and moderate-income residents to renovate later out of pocket. Few resources are available to help older adults subsidize the cost of home modifications. Implementing policies that establish visitability and/or universal design in new construction is a long-term, cost-effective method for creating housing stock that is flexible with the needs of residents. At the time of the 2012 Status of Seniors Initiative Update, visitable design was quoted at less than $1,000 per structure in new residential construction.

Community Feedback
Conversations with interview and focus group participants affirmed that prior research on affordable housing and older adults still holds true today. If anything has changed in this landscape, it may be that the need is greater than before and impacts a wider segment of the population, not just low-income and very-low income households. Affordable housing themes arising from conversations with participants include:

- The need for more education on reverse mortgages to help home owners access the equity of their homes as income
- The need for re-purposing foreclosed homes and other underutilized properties as aging-friendly, affordable housing
- The need for Naturally Occurring Retirement Community Supportive Service Programs, Villages, and other models to maintain affordability of current housing through enhanced access to services such as repairs and renovations
- The need for more affordable and accessible options for low- and middle-income renters in addition to homeowners
Strategies for Positive Change
The paradox of the increase in demand for affordable housing together with declining supply calls for creative action to help older adults find and maintain affordable, accessible, and safe homes. Strategies for positive change include:

- Community members can organize to develop supportive housing communities such as Villages. These communities can include contracts with local repair companies and contractors to offer household repair and renovation services at a discount to members of the Village.

- Service providers can organize to implement models such as Naturally Occurring Retirement Community Supportive Service Programs (NORC-SSPs) that can serve both homeowners and renters. NORC-SSP services may include home repairs and renovations provided by volunteers or by professionals at discounted rates.

- Service providers can campaign to educate older adults on reverse mortgages and available affordable housing options.

- Planners and leaders can establish policies to transform foreclosed housing and other underutilized properties into affordable, age-friendly housing.

- Planners and leaders can adopt policies establishing affordable and accessible housing units in resource-rich areas of the county, such as along major transit lines.

- Planners can adopt universal design and/or visitability standards in zoning ordinances and/or offer incentives for developers to use these principles in order to increase the supply of accessible housing.
Transportation

Transportation was the most frequently talked about need. As people age, flexible transit systems and transportation options become more important. Aging expert Howard Gleckman aptly stated that for the elderly and people with disabilities, “something as simple as a ride to the supermarket or the doctor may be the difference between staying at home and having to move.” Many residents in Mecklenburg County have unmet transportation needs, and demand consistently outpaces supply. The following summarizes strengths and needs related to transportation.

Current Strengths and Needs Status

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<td>Mecklenburg County has a wide range of public, private, and nonprofit transportation services available through organizations such as Charlotte Area Transit System, Department of Social Services, American Red Cross, Metrolina Association for the Blind, Shepherd’s Center, and Disabled American Veterans.</td>
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<tr>
<td>Innovative transportation options have been launched recently through organizations and companies including Charlotte B-cycle, Centralina Council of Governments’ Volunteer Transportation Service (VTS), Uber, and Lyft.</td>
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<td>Street safety and design have improved markedly in Charlotte due to implementation of Complete Streets and Urban Street Design Guidelines.</td>
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<td>More medical and general-purpose transportation is needed for older adults who cannot drive.</td>
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<td>More transportation services are needed for residents living in suburbs, as well as assistance accessing and navigating existing transportation options.</td>
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<td>The environment as a whole needs to foster greater mobility.</td>
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<td>Low-cost and no-cost transportation options are needed.</td>
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Findings
Recent data on the transportation patterns of older adults indicate most choose to travel by car. AARP’s 2009 National Household Travel Survey found that when people over age 65 traveled, they used public transit only 2.2% of the time, compared with traveling by car 87% of the time and on foot 8.8% of the time.\textsuperscript{46} Transportation data at the county level are limited; however, examining means of transportation to work for people age 65 and older who are in the labor force suggests, similar to the general working population, most local older adults are traveling by car. In 2012, 75% drove alone, 15% worked from home, 8% carpooled, 1% used public transportation, and 1% traveled by taxi, bike, or other means (Figure 19).\textsuperscript{47}

The majority of householders age 65 and older in Mecklenburg County have a personal vehicle (Figure 20). In 2012, 89% reported having one or more vehicles available; however, it is unknown how many of these vehicles are functional or how many of the householders are able to drive the vehicles.\textsuperscript{48}
There is a lack of data on the travel patterns for the older population in general, especially those who cannot drive. Nevertheless, it is safe to say that existing transportation services are underutilized and inefficient. Past studies have identified multiple factors influencing underutilization that are still relevant today, including but not limited to:

- Centralization of transportation services in Charlotte
- Long wait times between some buses
- Long distance between some residences and public transit stops
- Lack of awareness about available services
- Cultural resistance to public transit
- Inadequate affordable transportation options
- Inadequate transportation services outside of regular business hours
- Lack of coordination between transportation providers
- Inability of many vehicles to accommodate those with disabilities
- Strict eligibility requirements for subsidized services
- Lack of para-transit (individually scheduled rides), especially outside the Charlotte Area Transportation System service area
- Reductions in funding for subsidized programs such as the Mecklenburg Transportation System operated by the Mecklenburg County Department of Social Services

Several new transportation initiatives aim to address these barriers, including but not limited to Centralina Council of Governments’ (CCOG) Mobility Management Project and Volunteer Transportation Service, Charlotte B-cycle’s bike-sharing program, and private ride-sharing services through companies such as Uber and Lyft.

- CCOG’s Mobility Management Project will help residents navigate existing transportation options in CCOG’s nine-county region, including Mecklenburg County. The project features the launch of a Volunteer Transportation Services (VTS) program. VTS will offer affordable, general-purpose, individually scheduled rides to veterans, individuals with disabilities, and older adults who are otherwise unable to obtain transportation.

- Charlotte B-cycle has established 24 bike-sharing stations around Charlotte to promote health, wellness, and alternative transportation. The bike-sharing program is fee-based and requires a pass or membership.
Private ride-sharing companies such as Uber and Lyft are attempting to reinvent the way people travel by connecting riders with drivers through apps. These companies are creating a cheaper market for rides and increasing availability of cars. Debate is taking place across the country regarding where these unregulated drivers fit within the regulations monitoring taxi companies and other private transportation providers. Uber and Lyft are so new that it is difficult to predict their impact on Mecklenburg County.

Transportation is not just about vehicles. It is also about how the built environment hinders or helps people as they move from place to place. Charlotte has seen vast improvements in street safety and design in recent years. Since the early 2000s, the Charlotte Department of Transportation has been designing “Complete Streets” that meet the needs of motorists, pedestrians, cyclists, and residents. In 2007, the Charlotte City Council made Complete Streets an official part of its planning policy by adopting the Urban Street Design Guidelines (USDG). The Status of Seniors Initiative and the Charlotte-Mecklenburg Council on Aging were instrumental in the adoption of these guidelines.

Prior to Complete Streets, Charlotte had “. . . no bicycling routes, an incomplete sidewalk network, little connectivity and too many cul-de-sacs.” Charlotte has since benefited from 12 redesigned intersections, over 100 sidewalk projects with more in the works, 26 streetscape and road conversion projects, 11 new or re-constructed thoroughfares, and over 50 miles of new bike lanes. Charlotte’s USDG policy is award-winning and has been recognized as a best practice for improving transportation safety. Similar innovations are needed throughout the county.
Community Feedback

Feedback from focus group and interview participants suggests current transportation issues are much the same as those identified in past studies. Ironically, transportation emerged as the greatest need facing older adults even though the majority of participants were still driving and able to get where they need to go. The methodology of this study required most participants to travel to the focus group or interview locations. The fact that transportation was the greatest concern overall indicates participants are noticing others who have this need, and/or transportation is the need they anticipate having the greatest impact on their own quality of life as they age. Transportation issues identified include:

- The need for greater access to medical and general transportation for older adults who cannot drive
- The need for assistance with accessing and navigating existing transportation services, particularly the public bus system, and especially for residents in the suburbs
- The overwhelming preference for affordable, reliable, convenient, and vetted personal taxi services
- The need for consistency among transportation providers in terms of eligibility requirements and age cut-offs
- The need for better sidewalks and street lighting, more benches and shelters at bus stops, and safer streets in general
Strategies for Positive Change

In addition to the innovative new programs and services that have already been described, there are several actions residents, service providers, and community leaders can take to improve transportation options. These actions include:

- Community members can organize to develop supportive housing communities such as Villages. These communities can include contracts with vetted transportation companies to offer services at a discount to members of the Village.

- Service providers can organize to implement models such as Naturally Occurring Retirement Community Supportive Service Programs (NORC-SSPs). NORC-SSP services commonly include volunteer-based transportation, transportation vouchers, or discounted private taxi service.

- Service providers can establish campaigns to educate residents throughout the county about what transportation services are available and how to navigate the public transit system.

- Transportation providers can collaborate to establish consistent eligibility requirements and age cut-offs when possible. Providers can coordinate to fill gaps in services for those living in the suburbs and for those with low incomes.

- Planners and leaders throughout the county can adopt policies establishing best practices for street safety and design such as Complete Streets.
Health and wellness surfaced as another critical area of need. Encompassing both physical and psychological well being, older adults’ health and wellness needs are changing rapidly as the aging population skyrockets and life expectancy increases. Fragmentation within the local health care network is a pervasive problem and poses a constant threat to individuals’ health. Resolving gaps in services will require county-wide commitment to increased coordination and collaboration.

The following sections elaborate upon four major health and wellness needs:

- Affordable and accessible health care
- Caregiving
- Social engagement
- Mental health
Affordable and Accessible Health Care

A plethora of local health resources contribute to affordable and accessible care for older adults. Federal policies related to Medicare and the Affordable Care Act also strengthen access to care. Without additional action, however, current problems related to health insurance coverage gaps, fragmented systems, and lack of services will worsen as the number of older adults requiring long-term, specialized care increases. The following outlines some of the strengths and needs related to affordable and accessible health care for older adults in Mecklenburg County.

Current Strengths and Needs Status

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<td>v Access to care generally improves for those who qualify for Medicare and were uninsured or underinsured before qualifying for Medicare.</td>
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<td>v The Affordable Care Act will gradually close the Medicare part D “doughnut hole” by 2020, resulting in a significant reduction in prescription medication costs for older adults. The doughnut hole is a gap in prescription coverage that often results in significant out-of-pocket medication costs. 57</td>
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<tr>
<td>v Mecklenburg County has a broad spectrum of health care services and facilities, including but not limited to two major hospital systems, eight free or low-cost health clinics, sixteen senior congregate meal sites, several adult day care centers, and numerous long-term care facilities such as nursing homes, assisted living centers, and continuing care retirement communities.</td>
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<td>v Medicare and Medicaid do not cover all long-term care services; therefore, most older adults still have a need for affordable health care.</td>
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<td>v As the population ages, demand for assistance for the growing number of people with self-care difficulties, dementia, and other chronic illnesses will increase. 58</td>
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<td>v According to the Cecil G. Sheps Center for Health Services Research, in 2012 Mecklenburg County had only ten physicians with a primary specialty in geriatrics. 59</td>
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Existing health care services and facilities in Mecklenburg County have limited capacity due to varying eligibility requirements, waiting lists, staffing shortages, costs, and lack of coordination.60

Findings

Medicare benefits dramatically reduce the number of people who are uninsured beyond age 65. Between 2009 and 2012, the percent of 45-54 year-olds in Mecklenburg County without health insurance increased from 16.4% to 20.4%, and the percent of uninsured 55-64 year-olds increased from 13.2% to 16.3%. In contrast, the percent of people age 65 and older without insurance remained consistently low, accounting for about 1% of the age group between 2009 and 2012 (Figure 21).61

Medicare and/or Medicaid benefits do not resolve all access to care issues. Medicare covers long-term care (i.e., nursing home care and assistance with activities of daily living) for short periods of time in specific circumstances, such as when recovering from an injury or illness. It does not cover ongoing assistance with activities of daily living such as bathing, eating, and dressing. Medicaid covers nursing home care, but only if a person’s income is below a certain threshold and almost all assets have been spent down.62 Dental, vision, and hearing coverage is lacking. Unless an individual has a low enough income to qualify for Medicaid or a high enough income to afford private services, long-term care may be financially out of reach. When the Affordable Care Act closes the Medicare Part D prescription coverage gap in

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2020, some of the long-term care cost burden will lift from the individuals who currently suffer. However, it is critical for the Mecklenburg community to create additional solutions before 2020.

One indicator of the rising need for long-term care is the percent of older adults with a self-care difficulty. From 2008 to 2012, the percent of individuals age 65 and older with a self-care difficulty in Mecklenburg County rose from 7.1% to 8.4% (Figure 22). In contrast, the percent of people ages 35-64 with a self-care difficulty remained very low, from 1.1% in 2008 to 1.8% in 2012. As baby boomers age, the percent of older adults with self-care difficulties will continue to increase.

Another harbinger of escalating demand for long-term care is the projected increase in the number of older adults with dementia and other chronic illnesses. The prevalence of chronic illness among older adults is evident from data on leading causes of death. Among Mecklenburg County residents age 65 and older, the top five causes of death in 2012 were cancer, heart disease, Alzheimer’s Disease, cerebrovascular disease, and chronic lower respiratory disease (Figure 23). These illnesses have been the top five causes of death since at least 2008. As average life expectancy increases, the number of individuals with one or more chronic illnesses will also increase, along with demand for care.

Of particular concern is the predicted rise in the number of people with Alzheimer’s Disease. The 2013 Mecklenburg County Community Health Assessment estimated that up to half of residents age 85 and older may have Alzheimer’s Disease. With a significant increase in the number of people age 85 and older just over the horizon, it is critical for the community to...
increase and improve supports for those living with Alzheimer’s as well as their caregivers.

Part of the solution could involve attracting more specialized geriatric physicians to the area and enhancing geriatric medical training for general practitioners. According to the Cecil G. Sheps Center for Health Services Research, in 2012 only ten physicians in Mecklenburg County reported geriatrics as a primary area of practice (Figure 24). Although the number of local physicians identifying as geriatric specialists has increased significantly since 2004, the supply of professionals is grossly inadequate for the size of the aging population. Based on 2012 U.S. Census data, ten geriatric specialists translate into approximately one specialist for every 9,102 people age 65 and older in Mecklenburg County.

**Community Feedback**

Health concerns raised during focus groups and interviews illustrate the story of a financially vulnerable middle class, a health care system that is daunting to navigate, and special populations at risk of negative outcomes. Health care affordability and accessibility issues highlighted by participants include:

- Concern that the uninsured and those with Medicare and/or Medicaid benefits receive lesser medical treatment than those with private insurance in terms of quicker discharges and lower quality of services received
- High co-pays and prescription costs presenting an obstacle to care, especially for middle-income individuals who do not qualify for Medicaid
- Concern about the possibility of bankruptcy due to medical bills, especially among the middle class
- The need for more affordable dental and eye care services
- The need for education about Medicare, including what it covers and does not cover, what part D is, and who is eligible for benefits
- The need for more continuous, coordinated care in addition to brief interventions such as those implemented by social workers in hospitals
- The need for more local doctors who specialize in aging issues
- The need for greater access to health care for vulnerable populations such as undocumented immigrants and adults with severe and persistent mental illness
Strategies for Positive Change
Local residents, service providers, and community leaders can take steps to increase access to and affordability of health care services in Mecklenburg County. The success of the following strategies requires stepping outside of traditional silos and committing to collaboration.

- Community members can organize to develop supportive housing communities such as Villages, co-housing communities, or other models that may include contracts with providers to offer health care services, wellness activities, and health education to members of the Village.

- Service providers can collaborate to deliver services directly into communities with large concentrations of older adults, thereby increasing access to care. Naturally Occurring Retirement Community Supportive Service Programs (NORC-SSPs) commonly offer health care services and wellness activities.

- Providers can streamline health care services by coordinating to establish consistent quality assurance measures, develop similar age cut-offs and eligibility requirements, and expand services to cover gaps in care for vulnerable populations.

- Health care leaders and employers can adopt policies requiring all health providers who serve older adults to participate in training on geriatric care.

- Providers can develop campaigns to educate residents on Medicare, Medicaid, local health care resources, and other relevant health and wellness issues.

- Community leaders can develop campaigns to attract more physicians who specialize in geriatric care and offer incentives for physicians to treat older adults.
Caregiving
Across the U.S., friends and family are the primary caregivers for 90% of community-dwelling older adults and people with disabilities.\footnote{68} Although data describing the characteristics of caregivers in Mecklenburg County are limited, it is likely these unpaid helpers provide the bulk of long-term care support for local older adults. Moreover, many caregivers are older adults caring for aging parents, spouses, friends, grandchildren, or other relatives. In order for caregivers to continue their invaluable roles long-term, they too must be supported. The following outline some of the major strengths and needs related to caregiving in Mecklenburg County.

Current Strengths and Needs Status

<table>
<thead>
<tr>
<th>Strengths</th>
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</thead>
<tbody>
<tr>
<td>✔️ In 2011, the North Carolina State Center for Health Statistics’ Behavioral Risk Factor Surveillance System found that 14.2% of respondents in Mecklenburg County reported providing regular care or assistance during the past month for friends or family members with health problems, chronic illnesses, or disabilities.</td>
</tr>
<tr>
<td>✔️ Mecklenburg County has numerous resources for caregivers, including but not limited to assistance through the Alzheimer’s Association, Department of Social Services, adult day care centers, and geriatric care managers.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Needs</th>
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</thead>
<tbody>
<tr>
<td>✔️ More support services are needed to counteract the psychological, physical, and financial strain that many caregivers experience.</td>
</tr>
<tr>
<td>✔️ Caregiving resources need to be decentralized and increased in the suburbs.</td>
</tr>
</tbody>
</table>

Findings
Friend and family caregivers are tremendous assets. In 2009, the estimated value of unpaid caregiving in North Carolina was $10.37 per hour.\footnote{69} In 2013, those caring for people with dementia and Alzheimer’s alone in NC provided 504 million hours of unpaid care valued at $6.27 million.\footnote{70} The total economic savings friend and family caregivers contribute to the state long term care system extends well beyond that figure. In addition to monetary value, friend and family caregivers benefit individuals and communities by helping people age in place for as long as possible. As the older adult population grows, the value of unpaid caregiving will increase along with the need for long-term care. All communities will face the challenge of how to meet demand for
long-term care in light of a shrinking pool of caregivers. By 2030, the ratio of potential friend and family caregivers ages 45-64 for every person age 80 and over will drop from 7:1 to 4:1, and by 2050 the ratio will be approximately 3:1.71

The data suggest a significant number of Mecklenburg County residents are engaged in caregiving. The North Carolina State Center for Health Statistics’ Behavioral Risk Factor Surveillance System found that 21.9% of Mecklenburg County respondents in 2009 and 14.2% of respondents in 2011 said they had provided regular care or assistance during the past month to a friend or family member with a health problem, long-term illness, or disability.72

Data on the relationships of caregivers to those they are caring for are lacking at the county level; however, the U.S. Census Bureau reports on grandparents raising grandchildren. Grandparents become primary caregivers for grandchildren in various circumstances, such as when the children’s parents face substance abuse, mental illness, incarceration, economic hardship, homelessness, divorce, or domestic violence.73 Grandparents raising grandchildren are often lifelines for youth who might otherwise end up on the streets or with unfamiliar foster parents.

In 2012, the U.S. Census Bureau found that 6,787 grandparents in Mecklenburg County were responsible for grandchildren under age 18 living with them (Figure 25).74 Between 2008 and 2012, the number of grandparent caregivers increased by 17%. There was a sharp spike in the number of grandparents responsible for grandchildren in 2010, possibly due to the impact of the recession on vulnerable families. Some parents may have become unable to care for their children as a result of financial hardship, the high cost of childcare, or other crises leading to more grandparents taking on the role of the primary caregiver.
Regardless of the relationship between the caregiver and the person being cared for, caregivers need support in order to cope with the multifaceted financial, physical, and psychological impact of their responsibilities. Caregiving can be positive and rewarding. Transitioning into and maintaining a caregiving role can also be stressful and may trigger feelings of grief, anger, loss, depression, resentment, or guilt. Mecklenburg County has numerous supports available for local caregivers. However, most are concentrated around the center of the county and are sparse in the suburbs. For example, of the roughly 14 adult day care centers in Mecklenburg County, zero are located in the northern part of the county. Moreover, feedback from focus group and interview participants indicates current resources may not be enough to provide lasting relief from caregiver burden.

Community Feedback
Caregiving issues discussed during focus groups and interviews validated the helpfulness of existing supports while also shedding light on service gaps. Participants painted a picture of the daily “juggling act” that is caregiving. Balancing the needs of the person they care for on one hand and the needs of spouses, partners, children, employers, and/or service providers on the other, the ball that remains suspended in the air is caregivers’ own needs. Mecklenburg County has some resources for caregivers; however, more affordable and accessible services are required in order to extend relief to a larger segment of the local caregiver population. Caregiving issues highlighted by participants include:

- The overwhelming need for respite and relief
- The need for more adult day care centers with some subsidized placements throughout the county and especially in the suburbs
- The need for more support groups for caregivers and for people with dementia
- The need for more accessible and affordable caregiver supports for those without insurance or adequate financial resources
- The need for increased social support for caregivers, who often experience the disappearance of their social lives in the midst of caregiving responsibilities
- The need for increased understanding of the daily “juggling act” caregivers face
- The need for tips for dealing with loved ones’ challenging behaviors such as aggression, anger, suspicion, confusion, and wandering
- The need for help planning and coping with transitions such as taking the car keys away, selling homes, moving loved ones to long-term care facilities, preparing finances, and end of life
- The need for help navigating bureaucracies such as health care systems, insurance companies, and government services
- The need for others to understand what it is like to be a caregiver and recognize/appreciate their work
- The need for more information about available services and facilities both for caregivers and those they care for
Strategies for Positive Change

Family caregivers in Mecklenburg County are linked with both challenges and opportunities. On the one hand, the need for support surpasses the capacity of available services. On the other hand, the greatest resource for family caregivers is often other caregivers who are in a position to lend unique understanding and experience. Leveraging the power of existing caregiver and service provider networks could go a long way toward meeting outstanding needs. Potential caregiver support strategies include:

- Caregivers can mobilize to create avenues for mutual support and advocacy such as peer support groups, forums, or social clubs.

- Caregivers and service providers can collaborate to educate the greater community, employers, and local leaders on the value and experiences of caregivers.

- Service providers in all sectors (for-profit, non-profit, public, and faith-based) can collaborate to expand respite and relief options for low- and middle-income caregivers through strategies such as subsidized placements or sliding scale fees.

- Service providers can coordinate to disseminate services, activities, and education throughout the county, targeting places with high concentrations of caregivers.

- Employers can assess the impact of caregiving on employee productivity and behavior, institute programs to assist caregivers in the workplace, and review workplace policies to ensure they are friendly and flexible for caregivers.
Social Engagement

Older adults and boomers identified social engagement as a pressing need. Often older adults face unique challenges to social engagement stemming from retirement, changes in mobility and physical function, or loss of loved ones. However, social engagement is a need throughout all stages of life. The benefits of social activity are greatest when engagement is continual, as it is more difficult to start becoming engaged than to continue being engaged. Mecklenburg County has plentiful avenues for social activity, yet some gaps persist. The following highlights opportunities and challenges.

Current Strengths and Needs

<table>
<thead>
<tr>
<th>Strengths</th>
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<tbody>
<tr>
<td>Mecklenburg County has hundreds of social and recreational activities for people of all ages through organizations such as Senior Centers, Parks and Recreation departments, YMCA, YWCA, and Shepherd’s Center.</td>
</tr>
<tr>
<td>The merger of Charlotte-Mecklenburg Senior Centers with Mecklenburg County’s Parks and Recreation Department will streamline access to social activities and strengthen programming for older adults.</td>
</tr>
<tr>
<td>Older adults and boomers who participated in this study indicated a strong desire to remain active and give back to the community.</td>
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<tr>
<th>Needs</th>
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<tbody>
<tr>
<td>More organized social activities are needed during evening hours and weekends.</td>
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<tr>
<td>Social activities need to be more accessible for those facing mobility challenges, lack of transportation, low incomes, and other barriers.</td>
</tr>
<tr>
<td>Those at high risk of social isolation need targeted social support, including residents of long-term care facilities and the 27% of Mecklenburg County residents age 65 and older who live alone.</td>
</tr>
<tr>
<td>A wider variety of social activities are needed to reflect the diversity of the aging population. Social activities designed for residents age 65 and older may not fit the needs of residents ages 50-64.</td>
</tr>
</tbody>
</table>
Discussion
Social engagement is critical to positive health outcomes and quality of life regardless of age. Among older adults, social activity and support are correlated with better cognitive function, better overall health, and fewer depressive symptoms. Yet older adults and family caregivers face unique challenges to staying socially engaged. Retirement, reduced mobility, driving cessation, loss of loved ones, and caregiving demands can increase the risk of isolation and loneliness. These risks are especially acute for older adults living alone.

The percent of residents age 65 and older living alone in Mecklenburg County decreased from 30% to 25% between 2008 and 2010 and increased to 27% by 2012 (Figure 26). As baby boomers age, the percent of older adults living alone is likely to grow.

In the absence of quantitative data on the social activity of local older adults, research at the national level is highlighted. A 2012 AARP Survey on Civic Engagement found that boomers and older adults have low to moderate levels of social involvement, group membership, community involvement, and volunteerism. Voting in presidential and local elections was the only form of civic engagement with majority participation. Social involvement tended to be personal in nature, centering on hobbies and leisure activities, entertaining or visiting friends, and religious or spiritual pursuits. The overall trend of declining civic engagement was linked with the Great Recession, socioeconomic status, and perceptions of influence. Compared with survey results from 1997, boomers and older adults in 2012 were found to have reduced optimism about their ability to influence community problems.

Some of these trends may apply to Mecklenburg, particularly the barriers to engagement. With the Great Recession’s impact on individual finances and funding streams, social activity centers for older adults have suffered reductions in revenue. Budget cuts have led to fewer trips, events, and meals or snacks. The pending merger of two major hubs for social engagement, Charlotte-Mecklenburg Senior Centers and Parks and Recreation, is promising in its possibility of re-energizing programs for older adults and buffering the impact of the economic downturn.
Multiple barriers prevent available social resources from realizing full potential. One of the greatest impediments is fragmentation among services and groups. There is little county-wide outreach or coordination between organizations. The merger of Senior Centers with Parks and Recreation will help with this problem. A more complex dilemma is divisiveness between community members who identify differently in terms of race, ethnicity, sexual orientation, age, nationality, religion, and other characteristics. Divisions within minority groups add to the tension. Anecdotal evidence indicates within-group and between-group fragmentation is a threat to social engagement and connectedness. Community resources can only go so far in increasing social engagement when participants and providers are not all welcoming and inclusive.

Other obstacles to maximizing resources include mobility limitations, lack of transportation, proximity to event locations, cost of activities, centers’ operating hours, and low awareness of resources. While these challenges are present across the county, residents of suburbs feel them the most. Like many other services, organized social activities are most plentiful in Charlotte. Older adults in other parts of the county experience greater difficulty learning about events and getting to them. It may be true that most social involvement is personal and informal, but that does not mean organized social engagement is unnecessary. Older adults expressed a strong desire to participate in both formal and informal activities.
Community Feedback
Older adults and boomers identified social engagement as one of the greatest needs facing the aging population. Providers were much less likely to mention social engagement as a pressing need. Social engagement themes shared by older adults and boomers include:

- The need for preventing isolation and promoting inclusion among older adults
- The need for targeted social activities for residents at risk of isolation, including single older adults and caregivers
- The need for neighbors to check on each other more often
- The need for more venues for furthering interests and opportunities for contributing to the community
- The need for informing older adults about volunteer opportunities and how to get involved in the community.
- The need for social activities outside of regular business hours
- The need for a dedicated and fully functioning Senior Center in north Mecklenburg
- The need for increased access to social activities for those with low incomes and lack of transportation
- The need for more men to be engaged in social activities
- The need for more activities geared toward boomers, who often get left out because most activities target younger or older members of the community and are offered at times when many boomers are working
Strategies for Positive Change
The greatest assets for improving social engagement are the people and services already in Mecklenburg County. Increased coordination, collaboration, and dialogue would go a long way toward addressing unmet social needs. Strategies for change include:

- Community members can engage in individual outreach to check on neighbors.
- Community members can organize neighborhood groups to check on neighbors and plan neighborhood social events.
- Community members can volunteer, join boards or committees, or serve as consultants or mentors. Community leaders can create and market opportunities for older adults to share time and talents.
- Community members and service providers can organize intergroup dialogue to counteract discrimination against marginalized groups such as LGBT (lesbian, gay, bisexual, transgender) individuals and racial/ethnic minorities.
- Community members and service providers can coordinate to include residents of long-term care facilities in social activities.
- Service providers can work together to coordinate and disseminate diverse social activities across the county at different times and locations, targeting boomers as well as older adults, and males as well as females.
- Service providers can collaborate to bring social events and activities directly into communities with large concentrations of older adults, thereby increasing access for vulnerable residents who are at risk of isolation and/or unable to travel.
- Church leaders can implement programs and activities for older adult members in order to keep them active and involved in the community.
Mental Health
County-level data on the mental health status of older adults are limited. However, participants in the current study and in past studies have communicated a need for specialized geriatric mental health services. This need is increasing in urgency as demographic change occurs. The following summarize major strengths and needs related to geriatric mental health care in Mecklenburg County.

Current Strengths and Needs

<table>
<thead>
<tr>
<th>Strengths</th>
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<tbody>
<tr>
<td>Mecklenburg County has some adult mental health resources available through Novant Health, Carolinas HealthCare, Mobile Crisis, Cardinal Innovations, counseling agencies, and other organizations.</td>
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<table>
<thead>
<tr>
<th>Needs</th>
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<tbody>
<tr>
<td>A specialized geriatric psychiatric unit and physicians with a primary specialty in geriatric psychiatry are needed. Currently Mecklenburg County has no specialized unit or physicians.</td>
</tr>
<tr>
<td>More resources are needed to serve the growing number of older adults with mental illness and Alzheimer's Disease.</td>
</tr>
<tr>
<td>Mental health services need to be more accessible for those who face barriers such as inadequate insurance coverage and transportation.</td>
</tr>
</tbody>
</table>

Findings
The mental health resources in Mecklenburg County are unable to meet demand for services. A Charlotte Observer article announcing the opening of the Carolinas HealthCare adult psychiatric hospital in Davidson illustrated this demand. According to the article, 10 to 25 patients sit in Carolinas HealthCare emergency rooms every day waiting for psychiatric beds to become available. At Novant Health, about 5 to 7 people per day are in the same situation.

It is unknown how many of those waiting for beds are older adults; however, the need for geriatric mental health care is apparent. The 2012 Behavioral Risk Factor Surveillance Survey (BRFSS) found that more than 30% of North Carolina residents ages 55-64, nearly 20% of those ages 65-74, and 15% of people age 75 and older reported experiencing poor mental health within the past 30 days. Poor mental health
includes stress, depression, and/or problems with emotions. Some respondents indicated experiencing poor mental health every day for the past 30 days: 7% of 55-64 year-olds, 4.8% of 65-74 year-olds, and 4.7% of those age 75 and older (Figure 27).²⁴

Although Mecklenburg County has mental health resources for adults, it lacks specialized geriatric care. According to the Status of Seniors Initiative 2012 Update, Carolinas Medical Center-Randolph had a geriatric specialty team until Mecklenburg County budget cuts eliminated it in 2010.²⁵ Specialization is necessary to address the unique health needs of older adults. For example, aging impacts how the body processes substances. Medications for young adults may be harmful for older adults. The Institute of Medicine (IOM) points to the fact that a large segment of older adults with mental health/substance use (MH/SU) conditions also have physical health conditions and/or cognitive and functional limitations. Co-existing conditions can complicate diagnosis, treatment, and caregiving arrangements.²⁶

Another reason why specialization is important is because some mental health conditions are more common in older adults than in younger people. The most frequent diagnosis among older adults is dementia, particularly Alzheimer’s Disease. Older adults are also more likely to have mild forms of depression.²⁷ Add to these factors the stigmas of aging and mental illness, and the need for specialists becomes clear.

The shortage of geriatric mental health care is concerning now and even more alarming in the context of demographic trends. As the number of people over age 65 reaches historic highs, the number of older adults with mental illness will increase at a faster rate than in the general population. Dr. Diliip Jeste, expert on aging and mental health, provides several reasons for this change:

- People born after World War II (i.e., the baby boomers) have high incidence of depression, anxiety and substance use disorders.
• Declining stigma is leading to increased identification and treatment of mental illness among older adults.

• Life expectancy of people with serious mental illness is increasing, though it is still 20 years shorter than the life span of the general population.\textsuperscript{88}

Given the projected growth in the number of older adults needing mental health care, the lack of action to improve resources and access to services could contribute to a mental health crisis. Now is the time to come together as a community to build on existing strengths, marshal additional resources, and break down barriers to care.

**Community Feedback**

Concerns related to mental health mirror some of the barriers revealed in the literature and statistics. Mental health themes shared by research participants include:

- The need for more local psychiatrists who accept Medicare
- The need for structured living environments to accommodate older adults with mental illness and also younger people with early onset dementia
- The need for assistance navigating insurance and local management entities
Strategies for Positive Change
Ultimately, providing adequate mental health care for a rapidly aging population will require systemic change in how mental health care is funded, how health professionals are trained, and how society views mental illness. In the meantime, there are steps residents, providers, and leaders can take to improve geriatric mental health care locally. These actions include:

- Community members can organize informal peer support groups or forums to share feedback and experiences related to caregiving for older adults with mental health challenges and navigating health care systems.

- Community members and service providers can campaign to reinstate a geriatric psychiatric unit.

- Community members and service providers can collaborate and campaign to reduce the stigma of mental health diagnosis and treatment.

- Primary care, mental health and aging service providers can coordinate to deliver holistic care for older adults with multiple conditions and to offer options for older adults with no insurance coverage or inadequate insurance coverage.

- Service providers can collaborate to bring mental and behavioral health care directly into communities with large concentrations of older adults.

- Health care leaders and employers can adopt policies requiring all health providers who serve older adults to participate in training on geriatric mental health care, including methods for early detection, treatment, and prevention of depression, dementia, and other conditions.
The final area of need emerging from this study was education and advocacy. Education includes public education and awareness, resource information, and lifelong learning. Advocacy encompasses promotion of the interests of the aging population as a whole as well as the needs of vulnerable sub-populations.

Education and advocacy form the foundation of all other needs identified by participants. Without adequate information about what resources are available and how to access them, it is difficult to meet any need. Without a recognized leader and voice for the aging population, efforts to create change are fragmented and weakened. Education and advocacy go hand-in-hand.

The following sections expand upon education and advocacy needs.
**Education**

Many organizations in Mecklenburg County are involved in education and awareness efforts related to the aging population. However, several challenges hinder the efficacy of these initiatives. The following outline highlights current strengths and needs related to education for and about older adults in Mecklenburg County.

**Current Strengths and Needs Status**

<table>
<thead>
<tr>
<th>Strengths</th>
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</thead>
<tbody>
<tr>
<td>✷ Numerous organizations promote public education and awareness of aging issues, including but not limited to the Alzheimer’s Association, Centralina Area Agency on Aging, Radio 4 the Ages, and AARP.</td>
</tr>
<tr>
<td>✷ Multiple channels provide information about local resources for older adults, such as Just1Call, <em>All About Seniors</em>, Senior Grapevine, and United Way 311.</td>
</tr>
<tr>
<td>✷ Several organizations offer lifelong learning events for older adults, including Senior Scholars, Davidson Learns, Shepherd’s Center, and Senior Centers.</td>
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<tr>
<th>Needs</th>
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<tbody>
<tr>
<td>✷ Organizations promoting education and awareness need to coordinate their efforts in order to increase impact.</td>
</tr>
<tr>
<td>✷ Information about local resources and activities needs to be better marketed.</td>
</tr>
<tr>
<td>✷ Literacy and communication challenges prevent many older adults from accessing available information and services.</td>
</tr>
</tbody>
</table>

**Findings**

Education for and about older adults falls within three broad categories: public education and awareness, resource information, and lifelong learning. Public education and awareness efforts target the entire community in order to promote knowledge of aging issues. Resource information increases knowledge about available services for individuals and families in need of assistance. Lifelong learning encourages ongoing cognitive and social engagement through classes, lectures, and workshops often designed specifically for those age 50 and older.
Mecklenburg County is fortunate to have activities in all three categories; however, they often have limited impact due to lack of coordination, inadequate marketing, and literacy and communication challenges. Participants said the top barriers keeping older adults from getting needs met are the lack of information about what resources are available and the difficulty of navigating the information that is available. Inadequate coordination among providers of information and poor marketing are part of the problem. These challenges are not unique to Mecklenburg County. The goal of a no-wrong-door, single-point-of-access approach to providing resource information has not been wholly realized, although groups such as Community Resource Connections for Aging and Disabilities and Just1Call are making progress.

Many education efforts do not account for literacy and communication issues. Though not a perfect indicator of literacy, people without a high school diploma or GED generally have lower reading and writing ability than those with more education. In 2012, 15% of adults age 65 and older in Mecklenburg County had not graduated from high school (Figure 28). 89 This percentage represents a gradual drop from 2007, when 20% did not graduate from high school. Yet the number is still high. Numerous participants, particularly those with lower educational attainment and lower incomes, experienced difficulty with basic reading and writing tasks. Past local researchers have made comparable observations. 90 A national assessment of adult literacy by the National Center for Education Statistics in 2003 demonstrated adults age 65 and older had the lowest literacy of all age groups. 91 Despite the prevalence of low literacy among older adults, the public has little awareness of the issue, resource information is often not available at a low reading level, and most lifelong learning venues cater to educated consumers. These barriers leave low-literacy older adults at risk for isolation and unmet needs.

Another communication issue is computer literacy. A 2012 study of digital and media literacy in Mecklenburg County found that 71% of adults age 55 and older report using the internet, compared with 88% ages 35-54 and 94% under age 35. 92 These data suggest online communications miss a significant portion of the older adult population.
Providers must be cognizant of this “digital divide” as they devise ways to communicate about resources and activities. Several local organizations such as Shepherd’s Center and Senior Centers offer computer literacy classes for older adults, but these services do not replace the need for diverse communication strategies.

Health literacy is a communication challenge specific to those providing education and information related to health care. The Institute of Medicine defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” Low health literacy may result in incorrect use of medications, missed appointments, and confusion about treatment plans. Such behaviors have been linked with increases in mortality, emergency room visits, and hospitalizations. Older adults with low health literacy are especially vulnerable because older adults use more medical services than the general population and have higher rates of chronic illness. Some local healthcare centers such as Novant Healthcare and Care Ring have already implemented techniques for helping patients improve their health literacy. Anyone providing public education and awareness, resource information, or lifelong learning related to healthcare should consider the importance of promoting health literacy.

Community Feedback
Participants acknowledged the existing education resources, while calling for more education at all levels of public education and awareness, resource information, and lifelong learning. Issues identified by participants include:

- The need for community-wide education about the opportunities and challenges that come along with aging
- The need for greater access to information about available resources
- The need for better marketing to older adults about available resources
- The need for providers who will follow up to make sure a person receives assistance
- The need for a true no-wrong-door and single-access approach to finding and securing resources
- The need for lifelong learning opportunities
- The need for education on specific topics such as retirement, long-term care, housing, and encore careers
Strategies for Positive Change
Residents, service providers, and community leaders can collaborate to improve public education, resource information, and lifelong learning in Mecklenburg County. Strategies for change include:

- Community members can organize informal peer support groups or forums to share feedback and experiences related to locating and securing resources.

- Community members and providers can collaborate to plan, market, and implement educational campaigns on aging issues.

- Providers can coordinate to implement a county-wide no-wrong-door, single-access approach to finding and securing resources, including follow-up to ensure those seeking help receive assistance.

- Providers can make sure they market through existing information hubs such as Just1Call, *All About Seniors*, and Senior Grapevine. Providers can commit to keeping this information up-to-date.

- Providers can make resource and educational information available in multiple formats (e.g., electronic, print, and other media) at an accessible reading level. Information should also be available in different languages when possible, particularly Spanish.

- Providers can bring information and educational programs directly into places with large concentrations of older adults, including long-term care facilities, neighborhoods, and churches.

- Employers can develop employee education programs on planning and preparing for retirement.

- Colleges and universities can increase marketing of lectures and learning opportunities to older adults.

- Health providers can collaborate to promote consistent use of proven health literacy tools.
Advocacy
Many local organizations engage in advocacy activities as part of their service to older adults. The efficacy of these activities is hindered by lack of coordination and the absence of a recognized voice for aging issues. The following list summarizes opportunities and challenges related to advocacy:

Current Strengths and Needs

<table>
<thead>
<tr>
<th>Strengths</th>
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<tbody>
<tr>
<td>➢ Several organizations in Mecklenburg County are involved in general advocacy for the aging population, including but not limited to the Charlotte-Mecklenburg Aging Coalition, AARP, the Centralina Area Agency on Aging, and historically the Charlotte-Mecklenburg Council on Aging.</td>
</tr>
<tr>
<td>➢ Some organizations engage in advocacy for vulnerable sub-populations of older adults, such as Disability Rights and Resources, the Department of Social Services, the Alzheimer's Association, and the Parkinson's Association.</td>
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<thead>
<tr>
<th>Needs</th>
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</thead>
<tbody>
<tr>
<td>➢ Advocacy efforts often suffer from lack of coordination and marketing.</td>
</tr>
<tr>
<td>➢ Certain populations are in need of more advocacy, including LGBT (lesbian, gay, bisexual, transgender) older adults, immigrants and refugees, and racial/ethnic minorities.</td>
</tr>
<tr>
<td>➢ A recognized advocate for the aging population is needed.</td>
</tr>
</tbody>
</table>

Findings
Of the many topics raised, advocacy was the most challenging to discuss with participants. In general, older adults were quicker to identify advocacy as a systems-level function than a concept with a direct connection to their daily lives. This hypothesis is supported by the observation that when focus group attendees were asked to talk about a time when they needed to advocate for themselves, the vast majority did not readily respond to the question. They almost invariably asked for a definition of advocacy and struggled to talk about how advocacy fit into their daily lives. A few mentioned voting or instances when they had communicated health care wishes to doctors.
In contrast, when conversation turned to the question of whether an organization that advocates for local older adults is needed, participants unanimously affirmed the necessity of such an organization. Many stated it is important for such an organization to exist in order to serve as a clearinghouse for information related to older adults, to secure and protect funding for aging-related services, and to ensure older adults and boomers are included in local decision-making processes. The majority of participants seemed to be unaware of existing local organizations that advocate for the aging population. Consensus arose that Mecklenburg County lacks a spokesperson for issues impacting boomers and older adults.

Mecklenburg County has several organizations that are involved with advocacy for the aging population, such as the Charlotte-Mecklenburg Aging Coalition, the Centralina Area Agency on Aging, and AARP. However, no single person or organization is designated as the “go-to” entity for aging issues in Mecklenburg County. As a result, advocacy efforts are fragmented, and a visible, recognized voice for the aging population is lacking. Inconsistent coordination and collaboration reinforce fragmentation and contribute to the phenomenon of operating in silos.

Multiple participants cited poor marketing as an additional barrier to advocacy efforts. Organizations involved with advocacy for older adults and boomers need to market activities in various formats, locations, and languages at an accessible reading level. Organizations should also evaluate how they communicate about advocacy itself. In this study, participants’ responses to the term “advocacy” suggest many people struggle to define the concept and do not relate to it at an individual level. Advocacy organizations need to find creative ways to communicate about their work and engage the people for whom they are advocating.
In addition to the lack of a visible, recognized voice for the aging population as a whole, participants pointed out the need for targeted advocacy for vulnerable sub-populations. Targeted advocacy refers to promotion of the rights, interests, and well-being of specific, focused issues or groups. Some of the older adult groups who could benefit from targeted advocacy in Mecklenburg County are:

- LGBTQ (lesbian, gay, bisexual, transgender, queer/questioning) individuals
- Survivors of elder abuse
- Racial and ethnic minorities
- Immigrants and refugees
- Women
- Homeless individuals
- Veterans
- Individuals living with severe mental illness
- Individuals living with disabilities
- Older adults and caregivers in the workforce

A few organizations are involved with advocacy for special populations. For example, the Centralina Area Agency on Aging houses the ombudsman, who protects the rights residents in long-term care facilities; the Department of Social Services investigates elder abuse and supports veterans; Disability Rights and Resources advocates for individuals with disabilities; and the Alzheimer’s Association advocates for those with Alzheimer’s Disease and their caregivers. Feedback from participants suggests targeted advocacy is needed beyond what these organizations are providing.

**Community Feedback**

Participants acknowledged existing education resources while calling for more education at all levels: public education and awareness, resource information, and lifelong learning. Issues identified by participants include:

- The perception that local government does not prioritize older adults
- The difficulty of relating to the term “advocacy”
- Unanimous agreement that an organization with a specific mission of advocating for older adults is needed
- The need for a local, grassroots voice for older adults in addition to advocacy from organizations such as AARP
- The need for advocacy for specific issues and populations such as LGBTQ individuals, immigrants, refugees, and individuals living with mental illness or disabilities
**Strategies for Positive Change**

Opportunities for community members, service providers, and leaders to improve advocacy for older adults in Mecklenburg County include:

- Community members can organize and engage in grassroots advocacy through actions such as letter-writing campaigns, phone calls and meetings with elected officials, petitioning, and voting.

- Community members who are representatives of vulnerable populations such as LGBTQ individuals or immigrants can conduct outreach to organize and engage members of vulnerable populations in advocacy efforts.

- The local aging network can designate one organization or person to serve as the “go-to” voice for aging issues in Mecklenburg County.

- Organizations that advocate for older adults can collaborate and coordinate to promote campaigns both for the aging population as a whole and also for vulnerable sub-populations.

- Local leaders can create opportunities for older adults and boomers to engage in decision-making through advisory councils, forums, or other means.

- With respect to advocating for vulnerable sub-populations, the local aging network can expand its impact by collaborating with other organizations in the community such as members of the Homeless Services Network.

- Organizations involved in advocacy can evaluate their marketing approach in order to identify opportunities for increased clarity, communication, and impact.

- Local leaders can make aging issues a clear priority in agendas and budgets.
Three fundamental challenges underlie the unmet needs identified in this community assessment: 1) Mecklenburg County lacks holistic long-term planning and preparation for the growth of the aging population, 2) Local leaders, service providers, and community members often operate in silos, and 3) Most resources and activities are centralized in Charlotte.

The following community recommendations present strategies for addressing these fundamental challenges within each sector of need: housing and accessibility, health and wellness, and education and advocacy.
Community Recommendation: Create Long-Term Solutions

Mecklenburg County has a plethora of short-term services to aid individuals in times of crisis. However, it lacks an equivalent focus on long-term planning to prepare for the aging population and prevent potential systemic crises resulting from demographic change. A strategic and sustained effort is needed to create, implement, and evaluate interventions that will shape the county into a more age-friendly community over time. Long-range plans and policies must strike the balance between responsiveness to pressing demands and adaptability to future needs. Leaders must work in concert with community members to design solutions that account for the diversity of the aging population and reflect the interests of current older adults as well as boomers.

It is recommended that Mecklenburg County increase efforts to develop long-term solutions for the aging population. The following ideas highlight potential solutions in each of the needs sectors:

### Housing and Accessibility

- Local planners and leaders can establish policies that promote aging in place by:
  - including universal design and visitability standards in zoning ordinances
  - locating amenities such as grocery stores or health care facilities in resource-poor areas
  - establishing affordable and accessible housing in resource-rich areas
  - locating affordable and accessible housing along transit lines
  - implementing best practices for street safety and design such as Complete Streets throughout the county
  - repurposing foreclosed housing and other underutilized or abandoned properties into affordable, age-friendly housing for renters and owners

### Health and Wellness

- Local leaders can campaign to attract physicians who specialize in geriatric health.
- Local leaders, health care providers, and community members can campaign to reinstate a geriatric psychiatric unit.
- Employers can review workplace policies to ensure they are friendly and flexible for working caregivers.
- Health care leaders and employers can adopt policies requiring all health providers who serve older adults to receive training on geriatric health and mental health care.
The local aging network can designate one organization or person to serve as the “go-to” voice for aging issues in Mecklenburg County.

Local leaders can prioritize aging issues in agendas and budgets.

Local leaders, service providers, and community members can organize systematic educational campaigns including the following:

- Employers can establish employee education programs on planning and preparing for retirement.
- Service providers can establish campaigns to educate residents throughout the county about how to access existing transportation, housing, health care, and other resources.
- Service providers and community members can campaign to reduce the stigma of mental health diagnosis and treatment.
- Service providers and caregivers can campaign to educate the greater community, employers, and local leaders on the value and experiences of caregivers.
- Local leaders, service providers, and community members can campaign to educate the community about issues impacting the aging population as a whole as well as vulnerable sub-populations including LGBTQ elders.

It should be noted that Mecklenburg County at one time had a vibrant, community-based long-term planning initiative focused on the aging population. The Status of Seniors Initiative (SOSI) is described in Appendix A. The results of the current study indicate the needs and recommendations identified through SOSI are still relevant, although SOSI has been inactive for the past few years. If the local aging network were to recognize one organization or person to act as the voice for aging issues, that advocate would be in an ideal role to reactivate SOSI. SOSI had excellent potential for becoming the platform for a county-wide aging plan with specific, measurable, attainable, realistic, and time-based goals, strategies, and outcomes. Buncombe County has a strong example of such a plan. It is recommended that Mecklenburg County revive support for SOSI and harness the initiative’s wealth of information to generate an effective aging plan.
Community Recommendation: Coordinate to Cover Service Gaps

Participants in this study indicated the greatest strengths of the Mecklenburg community lie within its existing resources. The county is home to a diverse array of public, private, non-profit, and faith-based service organizations. Unfortunately, the culture of operating in silos hinders the ability of available resources to satisfy unmet needs. Increased competition for limited funds is one factor contributing to the fragmentation of services. For many providers, however, collaboration could be a key to survival. By pooling supplies, personnel, and/or services, providers can expand the scope of their work while engaging in cost-sharing. Collaboration can also maximize the capacity of available resources to bridge gaps in services and reach underserved populations.

One of the greatest barriers to coordination and collaboration within the aging network is the absence of a recognized leader. Although several local coalitions and associations serve as forums for aging service providers to learn and network, no single spokesperson or organization has been designated as the voice for aging issues in Mecklenburg County. When asked to identify who advocates for local older adults, the majority of study participants were unable to name a specific person or organization. A recognized leader is needed to increase visibility of the aging population and coordinate the efforts of the aging network at a systems level.

It is recommended that the aging network name a person or organization to serve as the go-to source for aging issues in Mecklenburg County. It is also recommended that local leaders, providers, and community members develop strategic partnerships to serve the aging population as efficiently and cost-effectively as possible. Ideally, a recognized leader within the aging network would assist with developing these partnerships. The following highlights summarize methods for increasing coordination and collaboration in each of the three areas of need:

**Housing and Accessibility**

- Housing and transportation providers can coordinate to establish consistent service eligibility requirements and age cut-offs and to expand transportation options for those living in the suburbs and with low incomes.
- Service providers can coordinate to educate older adults about reverse mortgages and available affordable housing options.
- Community members can organize to develop Villages, co-housing communities, or other supportive housing models that promote aging in place by increasing access to and affordability of services such as household repair and transportation.
Health and Wellness

- Health care providers can work together to develop consistent age cut-offs and eligibility requirements and to expand health care options for low to moderate income residents as well as the uninsured or under-insured.
- Health providers can collaborate to promote consistent use of proven health literacy tools and quality assurance measures.
- Primary care, mental health and aging service providers can coordinate to deliver holistic care for older adults with multiple co-existing conditions.
- Providers can collaborate to increase accessibility of caregiver respite and support services through strategies such as subsidized placements or sliding fee scales.
- Church and faith leaders can coordinate programs and activities for older adult members in order to keep them active and involved in the community.
- Service providers and community members can coordinate to include residents of long-term care facilities in social activities.
- Caregivers can mobilize to create avenues for mutual support and advocacy such as peer support groups, forums, or social clubs.
- Community members can organize neighborhood groups to check on elderly neighbors and plan neighborhood social events for residents of all ages.

Education and Advocacy

- Local leaders can coordinate opportunities for older adults to participate in decision-making through advisory councils and forums.
- Local leaders, providers, and community members can collaborate to plan, market, and implement public educational campaigns on aging issues.
- Providers can market services through existing information hubs such as Just1Call, All About Seniors, and Senior Grapevine.
- Colleges and universities can coordinate to increase development and marketing of lifelong learning opportunities for older adults.
- Community members can organize peer support groups or forums to share feedback related to locating and securing resources.
- Community members can organize and engage in grassroots advocacy through actions such as letter-writing campaigns, phone calls and meetings with elected officials, petitioning, and voting.
- Community members who are representatives of vulnerable populations such as LGBTQ elders or immigrants can conduct outreach to organize and engage members of vulnerable populations in advocacy efforts.
Community Recommendation: Decentralize Resources

Another barrier preventing Mecklenburg County’s existing resources from achieving full capacity is the centralization of resources in Charlotte. The frequent use of the label “Charlotte-Mecklenburg” to reference the county as a whole demonstrates the extent to which Charlotte dominates the identity of Mecklenburg County. Although Charlotte is by far the most populous and fastest growing area of the county, it is essential to recognize that Mecklenburg County is also home to Matthews, Mint Hill, Cornelius, Pineville, Davidson, and Huntersville. Each of these towns has its own unique culture, strengths, and needs. Furthermore, older adults in Mecklenburg County are somewhat more concentrated around the perimeter of the county. Centralizing health and human services and social activities in Charlotte contributes to the isolation of older adults in the suburbs, especially those who no longer drive and are unable to navigate Charlotte’s transit system. Centralization creates additional barriers that prevent vulnerable older adults in outlying towns from getting basic needs met.

It is recommended that local leaders, providers, and community members circulate available resources throughout the county. It is essential to promote the delivery of services and activities directly into neighborhoods where people live whenever possible, rather than requiring people to come to providers for assistance. The following action items provide suggestions for decentralizing resources within each category of need:

### Housing and Accessibility

- Providers can organize to implement service delivery models such as Naturally Occurring Retirement Community Supportive Service Programs (NORC-SSPs). NORC-SSP’s bring resources including home repairs, transportation, and health care directly into residential areas with high concentrations of older adults.

### Health and Wellness

- Service providers can deliver health and caregiver support services directly into communities with large concentrations of older adults in order to increase access to care. One way to accomplish this type of service delivery is to form Naturally Occurring Retirement Community Supportive Service Programs (NORC-SSPs).
- Service providers can work together to coordinate and disseminate diverse social activities across the county at different times and locations, targeting boomers as well as older adults and males as well as females.
Education and Advocacy

- Providers can coordinate to implement a county-wide no-wrong-door, single-access approach to finding and securing resources, including follow-up to ensure those seeking help receive assistance.
- Providers can bring information and educational programs directly into places with large concentrations of older adults, including long-term care facilities, neighborhoods, and churches.
- Providers can distribute resource information county-wide in multiple formats (e.g., electronic, hard copy, auditory, visual), at an accessible comprehension level, and in different languages.
A secondary purpose of this study was to help the Charlotte-Mecklenburg Council on Aging (CMCOA) and other organizations involved with education and advocacy for older adults to identify promising programmatic and funding practices.

The following sections summarize findings from a review of twenty Councils on Aging in North Carolina and twelve organizations across the U.S. with a focus on education and advocacy for older adults. Comparison and analysis of the most prominent services and revenue streams across organizations inform the concluding recommendations.
Councils on Aging in North Carolina: Programmatic and Funding Trends

In order to assess how the activities of the Charlotte-Mecklenburg Council on Aging (CMCOA) compare with similar organizations, information was reviewed for the following 20 active Councils on Aging (COA) in North Carolina.

- Alleghany County Council on Aging
- Anson County Council on Aging
- Bertie County Council on Aging
- Buncombe County Council on Aging
- Catawba County Council on Aging
- Chatham County Council on Aging
- Cleveland County Council on Aging
- Cumberland County Coordinating Council on Older Adults
- Halifax County Council on Aging
- Henderson County Council on Aging
- Iredell County Council on Aging
- Jackson County Council on Aging
- Lenoir County Council on Aging
- Martin County Council on Aging
- Montgomery County Council on Aging
- Pitt County Council on Aging
- Polk County Council on Aging
- Rowan County Council on Aging
- Transylvania County Council on Aging
- Union County Council on Aging
Table 1 highlights services provided by 20 COAs in North Carolina. The data are based on services identified through Council on Aging websites, county government websites, and Council on Aging IRS Form 990s. The most significant theme is the predominance of direct services such as meals, transportation, social activities, and fitness programs. Many COAs also provide community education about aging issues and general advocacy for older adults by connecting them with needed resources. However, education and advocacy efforts by COAs are usually secondary to the mission of providing direct service and are limited in scope. Only one COA is involved in legislative advocacy. Four COAs provide education and advocacy by serving local governments in an advisory capacity. All other COAs engage in education and advocacy only in a very broad sense. In contrast, the CMCOA has a central mission of education and advocacy for older adults, which includes legislative advocacy and action related to specific issues impacting older adults.

Table 1. Services Provided by Twenty Councils on Aging in North Carolina
Source: Council on Aging websites; county government websites; GuideStar Nonprofit Directory

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Councils on Aging Providing the Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information and assistance</td>
<td>16</td>
</tr>
<tr>
<td>Nutrition and meal program</td>
<td>13</td>
</tr>
<tr>
<td>Companionship and socialization program</td>
<td>13</td>
</tr>
<tr>
<td>Transportation and travel assistance</td>
<td>12</td>
</tr>
<tr>
<td>Health and wellness program</td>
<td>12</td>
</tr>
<tr>
<td>Community education</td>
<td>12</td>
</tr>
<tr>
<td>General advocacy</td>
<td>12</td>
</tr>
<tr>
<td>In-home aide</td>
<td>10</td>
</tr>
<tr>
<td>Caregiver support program</td>
<td>9</td>
</tr>
<tr>
<td>Senior Health Insurance Information Program</td>
<td>8</td>
</tr>
<tr>
<td>Senior center operation</td>
<td>7</td>
</tr>
<tr>
<td>Heat relief or emergency utility assistance</td>
<td>6</td>
</tr>
<tr>
<td>Home maintenance and repair</td>
<td>5</td>
</tr>
<tr>
<td>Tax aid program</td>
<td>5</td>
</tr>
<tr>
<td>Legal assistance</td>
<td>5</td>
</tr>
<tr>
<td>Advisory, programming, and fundraising support for aging network</td>
<td>4</td>
</tr>
<tr>
<td>Senior employment program</td>
<td>3</td>
</tr>
<tr>
<td>Senior village operation</td>
<td>1</td>
</tr>
<tr>
<td>Affordable senior housing program</td>
<td>1</td>
</tr>
<tr>
<td>Age-friendly business certification</td>
<td>1</td>
</tr>
<tr>
<td>Transitions in care program</td>
<td>1</td>
</tr>
<tr>
<td>Legislative advocacy</td>
<td>1</td>
</tr>
<tr>
<td>Emergency cell phone assistance</td>
<td>1</td>
</tr>
<tr>
<td>Adult day care</td>
<td>1</td>
</tr>
</tbody>
</table>
The CMCOA has historically relied on local government and United Way funding. Table 2 reflects the funding sources of 13 out of the 20 COAs based on 2013 IRS Form 990s. The data indicate that most COAs have a mix of funding from contributions, grants, program service revenue, and other revenue sources. See Appendix D for a glossary of revenue source terminology.

Table 2. Revenue Sources of 13 Councils on Aging in North Carolina
Source: GuideStar Nonprofit Directory

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Number of COAs Reporting Revenue from Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other contributions, gifts, grants</td>
<td>13</td>
</tr>
<tr>
<td>Investment income</td>
<td>11</td>
</tr>
<tr>
<td>Government grants</td>
<td>10</td>
</tr>
<tr>
<td>Program service revenue</td>
<td>10</td>
</tr>
<tr>
<td>Miscellaneous revenue</td>
<td>7</td>
</tr>
<tr>
<td>Rental income</td>
<td>4</td>
</tr>
<tr>
<td>Income from fundraising events</td>
<td>3</td>
</tr>
<tr>
<td>Federated campaigns</td>
<td>3</td>
</tr>
<tr>
<td>Sale of inventory or assets</td>
<td>3</td>
</tr>
<tr>
<td>Income from gaming activities</td>
<td>1</td>
</tr>
<tr>
<td>Contributions from fundraising events</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3 presents the median and range amounts of the five most common revenue sources from 13 COAs based on 2013 IRS Form 990s. The data demonstrate that government grants are the largest revenue source, followed by other contributions, gifts, and grants and program service revenue. Investment income and miscellaneous revenues, although common, account for a small portion of total revenue. The prominence of grants and program service revenue suggests a significant amount of COA funding is linked with direct service provision.

Table 3. Median and Range Amounts of Top Revenue Sources for 13 Councils on Aging in North Carolina
Source: GuideStar Nonprofit Directory

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government grants</td>
<td>$334,950</td>
<td>$0 - $1,451,059</td>
</tr>
<tr>
<td>Other contributions, gifts, grants</td>
<td>$136,762</td>
<td>$3,155 - $490,517</td>
</tr>
<tr>
<td>Program service revenue</td>
<td>$93,586</td>
<td>$0 - $1,079,570</td>
</tr>
<tr>
<td>Miscellaneous revenue</td>
<td>$163</td>
<td>$0 - $5,143</td>
</tr>
<tr>
<td>Investment income</td>
<td>$84</td>
<td>$0 - $5,870</td>
</tr>
</tbody>
</table>
Two major themes emerge from the study of other COAs in North Carolina:

- The vast majority of COAs operate as direct service providers.
- COA revenues are derived from multiple sources and reflect the emphasis on direct service provision.

With its mission of systems-level education and advocacy and its reliance on a couple of revenue sources, the CMCOA is notably different from other COAs in North Carolina.

Another noteworthy trend is the movement toward rebranding and restructuring. COAs were often difficult to identify, partly because many are changing their names and/or integrating with other organizations. For example, the Davidson County Department of Senior Services evolved from the Davidson County Council on Aging. Community and Senior Services of Johnston County evolved from a Council on Aging, as did Randolph County Senior Adults Association and Aging, Disability, and Transit Services of Rockingham County. These former COAs were not included in the study because the goal was to identify the activities associated with organizations currently identifying as Councils on Aging. However, the rebranding and restructuring trend is significant and suggests COAs are evolving to achieve relevance and sustainability.
Education and Advocacy-Focused Organizations: Programmatic and Funding Trends

A brief assessment of organizations focused on education and advocacy for older adults was conducted to benefit the CMCOA as well as other local groups with an interest in these activities. Twelve nonprofits across the U.S. were included in the assessment:

- Action for Older Persons – Binghamton, NY
- Athens Community Council on Aging – Athens, GA
- Center for Advocacy for the Rights and Interests of the Elderly – Philadelphia, PA
- Community Living Campaign – San Francisco, CA
- Council of Senior Citizens and Services of New York City – New York, NY
- Council on Aging of Greater Nashville – Nashville, TN
- Council on Aging of Orange County – Santa Ana, CA
- Elders in Action – Portland, OR
- Grassroots Organization for the Well-Being of Seniors – Potomac, MD
- Senior and Disability Action – San Francisco, CA
- The Senior Source / Senior Citizens of Greater Dallas – Dallas, TX
- Wise and Healthy Aging – Santa Monica, CA
Table 4 highlights services provided according to the organizations’ websites and IRS Form 990s. All of the nonprofits offer community education and some form of systems-level advocacy. The majority engages in targeted advocacy, meaning the organizations advocate for or against specific issues impacting older adults such as elder abuse, long-term care, aging in place, health care reform, or food insecurity. Most complement systems-level interventions with direct services. Information and assistance are the most common direct services. Otherwise, services vary from end of life planning to health insurance counseling to social activities. The main point is that organizations focused on education and advocacy for older adults typically do not carry out these activities solely at the systems level. Instead, they complement systems advocacy with direct advocacy and assistance for individuals.

Table 4. Services Provided by 12 Education and Advocacy-Focused Nonprofits in the U.S.
Source: Organizational websites; GuideStar Nonprofit Directory

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Organizations Providing the Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community education</td>
<td>12</td>
</tr>
<tr>
<td>Targeted systems advocacy</td>
<td>10</td>
</tr>
<tr>
<td>Information and assistance</td>
<td>10</td>
</tr>
<tr>
<td>Ombudsman</td>
<td>6</td>
</tr>
<tr>
<td>Legislative advocacy</td>
<td>6</td>
</tr>
<tr>
<td>Health insurance counseling and advocacy</td>
<td>6</td>
</tr>
<tr>
<td>Socialization or companionship program</td>
<td>5</td>
</tr>
<tr>
<td>Professional training</td>
<td>4</td>
</tr>
<tr>
<td>Nutrition and meal program</td>
<td>3</td>
</tr>
<tr>
<td>Caregiver support program</td>
<td>3</td>
</tr>
<tr>
<td>Financial counseling</td>
<td>3</td>
</tr>
<tr>
<td>Community-based living advocacy</td>
<td>3</td>
</tr>
<tr>
<td>Economic security advocacy</td>
<td>2</td>
</tr>
<tr>
<td>Elder abuse prevention</td>
<td>2</td>
</tr>
<tr>
<td>Speaker’s bureau</td>
<td>2</td>
</tr>
<tr>
<td>Adult day care</td>
<td>2</td>
</tr>
<tr>
<td>Senior village or co-op operation</td>
<td>2</td>
</tr>
<tr>
<td>Senior employment program</td>
<td>2</td>
</tr>
<tr>
<td>Transportation</td>
<td>2</td>
</tr>
<tr>
<td>Health and wellness program</td>
<td>2</td>
</tr>
<tr>
<td>In-home aid</td>
<td>2</td>
</tr>
<tr>
<td>Age-friendly business certification</td>
<td>2</td>
</tr>
<tr>
<td>Senior center operation</td>
<td>1</td>
</tr>
<tr>
<td>Disability advocacy</td>
<td>1</td>
</tr>
<tr>
<td>Technical assistance and leadership training</td>
<td>1</td>
</tr>
<tr>
<td>for aging network organizations</td>
<td></td>
</tr>
<tr>
<td>Housing advocacy</td>
<td>1</td>
</tr>
<tr>
<td>Advance planning for end of life</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 5 displays the revenue sources for 10 out of the 12 education and advocacy-focused organizations based on 2013 IRS Form 990s. The data indicate that most organizations operate with a variety of funding from contributions, grants, program service revenue, and other revenue sources. The most common revenue sources for education and advocacy-focused organizations parallel the most common revenue sources for Councils on Aging, with the exception that more education and advocacy-focused organizations generate income from fundraising events.

Table 5. Revenue Sources of Ten Education and Advocacy-Focused Nonprofits in the U.S.
Source: GuideStar Nonprofit Directory

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Number of Nonprofits Reporting Revenue from Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other contributions, gifts, grants</td>
<td>10</td>
</tr>
<tr>
<td>Investment income</td>
<td>9</td>
</tr>
<tr>
<td>Program service revenue</td>
<td>8</td>
</tr>
<tr>
<td>Income from fundraising events</td>
<td>6</td>
</tr>
<tr>
<td>Contributions from fundraising events</td>
<td>6</td>
</tr>
<tr>
<td>Government grants</td>
<td>6</td>
</tr>
<tr>
<td>Miscellaneous revenue</td>
<td>5</td>
</tr>
<tr>
<td>Federated campaigns</td>
<td>4</td>
</tr>
<tr>
<td>Rental income</td>
<td>3</td>
</tr>
<tr>
<td>Sale of inventory or assets</td>
<td>3</td>
</tr>
<tr>
<td>Membership dues</td>
<td>2</td>
</tr>
</tbody>
</table>

The median and range amounts of the seven most common revenue sources further illuminate funding trends. The largest revenue amounts typically come from program service fees or contracts, government grants, contributions from fundraising events, and other contributions, gifts, and grants. Investment income, miscellaneous revenue, and income from fundraising events generally account for smaller amounts.

Table 6. Median and Range Amounts of Top Revenue Sources for Ten Education and Advocacy-Focused Nonprofits in the U.S.
Source: GuideStar Nonprofit Directory

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program service revenue</td>
<td>$221,766</td>
<td>$0 - $3,372,615</td>
</tr>
<tr>
<td>Other contributions, gifts, grants</td>
<td>$220,940</td>
<td>$27,317 - $1,043,612</td>
</tr>
<tr>
<td>Government grants</td>
<td>$190,806</td>
<td>$0 - $3,255,681</td>
</tr>
<tr>
<td>Contributions from fundraising events</td>
<td>$21,253</td>
<td>$0 - $721,158</td>
</tr>
<tr>
<td>Investment income</td>
<td>$413</td>
<td>$0 - $81,438</td>
</tr>
<tr>
<td>Miscellaneous revenue</td>
<td>$9</td>
<td>$0 - $3,600</td>
</tr>
<tr>
<td>Income from fundraising events</td>
<td>$0</td>
<td>- $29,498 - $34,873</td>
</tr>
</tbody>
</table>
Several themes emerge from the study of organizations with a mission centered on education and advocacy for older adults:

- The majority of these organizations provide direct services in conjunction with systems-level education and advocacy.
- Advocacy activities target specific issues impacting older adults.
- Revenue sources are diverse and reflect the variety of services and activities provided.

These findings suggest the CMCOA’s traditional operating model is not sustainable. In order to develop new revenue streams, the CMCOA would likely need to provide direct services in addition to its traditional systemic education and advocacy initiatives.

One of the organizations included in this study, the Center for Advocacy for the Rights and Interests of the Elderly (CARIE), has implemented an especially innovative operating model throughout Pennsylvania. CARIE’s sole purpose is to advocate for vulnerable older adults. To accomplish this mission, CARIE follows a “cause to cause” model featuring a “circle of advocacy” (Figure 29). By addressing individual causes and needs through direct advocacy services, CARIE becomes aware of changes needed within the long term care system. CARIE then pursues systemic causes through education and public policy initiatives. CARIE forms a circle of advocacy by moving from individual causes to systemic solutions that benefit all individuals.97 CARIE’s direct advocacy services include a hotline, an Ombudsman program, transportation advocacy, and victim advocacy.

In an environment of increasing competition for scarce economic resources, those serving older adults must be strategic, efficient, and results-oriented. Organizations such as CARIE provide a foundation for emulating effective practices.
Recommendations for Education and Advocacy-Focused Organizations

The results of this study indicate that organizations focused on education and advocacy for older adults are relevant and needed in Mecklenburg County. Participants consistently stated the importance of having a local organization to serve as a hub for information and a voice for issues impacting older adults and boomers. Preliminary findings from the comparative analysis lead to the following programmatic and funding recommendations for organizations dedicated to education and advocacy for the aging population, including the Charlotte-Mecklenburg Council on Aging (CMCOA):

Integrate Direct and Systemic Interventions

- Organizations implementing education and advocacy activities solely at the systems level are in the minority. It is recommended that education and advocacy-focused organizations complement systemic interventions with direct services.
- All activities should be strategic and clearly connected to the organization’s core mission. It is recommended that systems-level education and advocacy efforts target specific issues impacting older adults and boomers, such as long-term care or aging in place. It is recommended that direct services have a clear relationship to the organization’s systems interventions.
  - The Center for Advocacy for the Rights and Interests of the Elderly (CARIE) provides an excellent model for providing advocacy both as a direct service and as a systemic intervention. For example, CARIE offers direct support to elderly victims of crime while also educating the public about elder abuse and advocating for policies to prevent elder abuse.
- Possible direct service markets to consider in Mecklenburg County include aging in place, affordable housing, geriatric mental health, or caregiver support.

Diversify Revenue Streams

- It is recommended that organizations diversify revenue streams. The most fruitful sources of funding for direct services may include government grants, fees and contracts for services, donations, and other grants. The most significant sources of funding for non-direct activities may include fundraising, program fees, donations, and other grants and contributions.
- Recent trends indicate foundations such as the MacArthur Foundation and the Foundation for the Carolinas may be developing increased interest in initiatives supporting the aging population, especially those related to aging in place.
Brand and Market

- It is recommended that organizations adopt a clear and creative brand. Assessment of other Councils on Aging (COAs) demonstrates many of these organizations are moving away from the generic COA title and adopting more descriptive brands. In contrast with COAs, the titles of many of the education and advocacy organizations across the U.S. are unique, poignant, and succinct. When carried out well, branding is a strong tool for marketing an organization’s mission and activities, thereby attracting potential consumers and donors.

- It is recommended that organizations serving Mecklenburg County as a whole avoid the label “Charlotte-Mecklenburg” in their brands and instead focus on brands that promote inclusivity of the entire county. Emphasizing Charlotte when branding and marketing may have the unintended consequence of excluding those in the suburbs.
Conclusion

The growth of the aging population is not a problem to be solved, but an opportunity to be embraced. Actions that make a community more senior-friendly ultimately benefit all residents. Demographic change presents an opportunity for Mecklenburg County to become a model livable community. With several best practices already in place (e.g., Program of All-Inclusive Care for the Elderly, Complete Streets) and others in the works (e.g., Volunteer Transportation Service, possible Senior Village in Davidson), Mecklenburg County is developing pockets of innovation with the potential to catalyze county-wide planning and preparation for the aging population.

The key to effective and efficient action is not to wait for external funding that will likely never come, but to harness the power of existing infrastructure and human capital. Whether unmet needs fall within the area of housing and accessibility, health and wellness, or education and advocacy, strategic partnerships are critical to bridging gaps between supply and demand. Community members, service providers, leaders and planners alike must step out of traditional silos to effect change. Older adults and boomers should have a place as valued contributors to the decisions and direction of the community as a whole.

Along with strategic partnerships, a recognized advocate is needed to promote the interests of the aging population, to serve as the go-to source for aging issues, and to ensure ongoing commitment to long-term planning, coordination and collaboration, and decentralization of resources. Such an advocate would amplify the efforts of the aging network as a whole and facilitate the transformation of plans into actions.

The limitations of this research must be acknowledged. County-level data on older adults and boomers were lacking in many categories, including social activity, mental health, and caregiving. Participants self-selected into the study and did not reflect a representative sample. Several key groups were missing or under-represented, including but not limited to those who are homebound or living in long-term care facilities, LGBT individuals, people with disabilities, and racial and ethnic minorities. The number of participants who were included and the data collection methods were shaped by the study’s short time frame, lack of funding, and small research team.

Future research should feature a systematic survey of a representative random sample of the local aging population. Regular assessment of local older adults would contribute to data-driven decision-making about how best to serve the aging population. Data collection tools should be designed to accommodate people of all backgrounds, including those with low literacy levels, those who communicate in languages other than English, and those who are vision or hearing-impaired.
References


-----. National Household Travel Survey. (2009).


Cecil G. Sheps Center for Health Services Research. North Carolina Health Professions Data System.

Center for Advocacy for the Rights and Interests of the Elderly.

Centralina Council of Governments, Area Agency on Aging.


Charlotte.bcycle.com


Guidestar Nonprofit Directory.


Mecklenburg County Department of Social Services, Services for Adults Division.


National Center for Education Statistics. *National Assessment of Adult Literacy.*


----. *North Carolina Health Data Query System*


UNC Charlotte Urban Institute, 2010 Annual Survey.


----. Population Estimates.


Endnotes

1 US Census Bureau, *Population Estimates* (County Characteristics Datasets), Table: Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin, April 1, 2010 to July 1, 2012, North Carolina.
2 North Carolina Office of State Budget and Management. *Projected County Totals – Single Year of Age*, Table: July 1, 2030 County Total – Single Year Ages; Note: These projections were last updated September 25, 2013.
6 North Carolina Office of State Budget and Management. *Projected County Totals – Single Year of Age*, Tables: July 1, 2015 County Total – Single Year Ages; July 1, 2020 County Total – Single Year Ages; July 1, 2025 County Total – Single Year Ages; July 1, 2030 County Total – Single Year Ages. Note: These projections were last updated September 25, 2013.
7 Mecklenburg County Department of Social Services, Services for Adults Division, interview with UNC Charlotte Urban Institute, November 2013.
8 US Census Bureau, *American Community Survey (One-Year Estimates)*, Table B17001: Poverty Status in the Past 12 Months by Sex by Age.
9 US Census Bureau, *American Community Survey (One-Year Estimates)*, Table B23001: Sex by Age by Employment Status for the Population 16 Years and Over.
11 North Carolina Office of State Budget and Management. *Projected County Totals – Single Year of Age*, Tables: July 1, 2015 County Total – Single Year Ages; July 1, 2020 County Total – Single Year Ages; July 1, 2025 County Total – Single Year Ages; July 1, 2030 County Total – Single Year Ages. Note: These projections were last updated September 25, 2013.
14 US Census Bureau, *American Community Survey (One-Year Estimates)*, Table DP05: ACS Demographic and Housing Estimates.

US Census Bureau, *American Community Survey (One-Year Estimates)*, Table B15001: Sex by Age by Educational Attainment for the Population 18 Years and Over.


US Census Bureau, *American Community Survey (One-Year Estimates)*, Table B17001: Poverty Status in the Past 12 Months by Sex by Age.

US Census Bureau, *American Community Survey (One-Year Estimates)*, Table B23001: Sex by Age by Employment Status for the Population 16 Years and Over.

Ibid.


US Department of Housing and Urban Development, “Measuring the Costs and Savings of Aging in Place.”


UNC Charlotte Urban Institute, *2010 Annual Survey*.


US Census Bureau, *American Community Survey (One-Year Estimates)*, Table B09020: Relationship by Household Type (Including Living Alone) for the Population 65 Years and Over.

US Census Bureau, *American Community Survey (One-Year Estimates)*, Table B18107: Sex by Age by Independent Living Difficulty.

31 Kelly Carr et al., “Universal Design: A Step Toward Successful Aging.”
32 North Carolina State University, “Universal Design Demonstration Home.”
33 Kelly Carr et al., “Universal Design: A Step Toward Successful Aging.”
36 Ibid.
40 US Census Bureau, American Community Survey (One-Year Estimates), Table B25093: Age of Householder by Selected Monthly Owner Costs as a Percentage of Household Income in the Past 12 Months.
41 US Census Bureau, American Community Survey (One-Year Estimates), Table B25072: Age of Householder by Gross Rent as a Percentage of Household Income in the Past 12 Months.
43 US Census Bureau, American Community Survey (One-Year Estimates), Table B25126: Tenure by Age of Householder by Year Structure Built.
46 AARP, National Household Travel Survey, (2009).
47 US Census Bureau, American Community Survey (One-Year Estimates), Table B08101: Means of Transportation to Work by Age.
48 US Census Bureau, American Community Survey (One-Year Estimates), Table B25045: Tenure by Vehicles Available by Age of Householder.

50 Centralina Council of Governments, Area Agency on Aging, telephone conversation with UNC Charlotte Urban Institute, April 2014.

51 Charlotte.bcycle.com


55 Charlotte Department of Transportation, “Urban Street Design Guidelines”; AARP, “Aging in Place, Stuck without Options: Fixing the Mobility Crisis Threatening the Baby Boom Generation.”


59 Cecil G. Sheps Center for Health Services Research, North Carolina Health Professions Data System, Health Professions Tables: Physician Specialties.


61 US Census Bureau, American Community Survey (One-Year Estimates), Table B27001: Health Insurance Coverage Status by Sex by Age.

US Census Bureau, *American Community Survey (One-Year Estimates)*, Table B18106: Sex by Age by Self-Care Difficulty.


Mecklenburg County Health Department, Epidemiology Program, “2013 Mecklenburg County Community Health Assessment.”

Cecil G. Sheps Center for Health Services Research, *North Carolina Health Professions Data System*.


US Census Bureau, *American Community Survey (One-Year Estimates)*, Table B09020: Relationship by Household Type (Including Living Alone) for the Population 65 Years and Over.

AARP, “Civic Engagement Among Mid-Life and Older Adults: Findings from the 2012 Survey on Civic Engagement” (December 2012), Retrieved from

86 Institute of Medicine of the National Academies, “Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?” (July 2012), Retrieved from http://www.iom.edu/Reports/2012/The-Mental-Health-and-Substance-Use-Workforce-for-Older-Adults.aspx
87 Ibid.
88 Courtney Reyers, “The Depression Boom: As U.S. Population Ages, Mental Illness Rises.”
89 US Census Bureau, American Community Survey (One-Year Estimates), Table B15001: Sex by Age by Educational Attainment for the Population 18 Years and Over.
90 Mecklenburg County Department of Social Services Research, Planning, and Evaluation Unit. “Aging-in-Place Survey.”
91 National Center for Education Statistics, National Assessment of Adult Literacy, Table: Race/Age (2003).
Appendix A:
Previous Community Assessments

Overview of the Status of Seniors Initiative
The Status of Seniors Initiative (SOSI) was a landmark effort to identify issues facing the aging population and implement strategies to resolve unmet needs. In May 2002, the Board of County Commissioners charged the Department of Social Services and the Social Services Committee of the Health and Human Services Council with the task of producing an annual report on the status of seniors in Mecklenburg County. The resulting 2003 Status of Seniors Report led directly to the 2003-04 SOSI strategic planning process.

Supporting partners of the strategic planning process included United Way of Central Carolinas, Centralina Area Agency on Aging, Charlotte-Mecklenburg Council on Aging, Department of Social Services, Mecklenburg County Board of County Commissioners, the Lee Institute, the Charlotte-Mecklenburg Aging Coalition, and numerous other representatives from the local aging network and broader community.

The strategic planning process began with investigation of five major areas of need identified in the 2003 Status of Seniors Report:

- Facilities and institutions
- Food and nutrition
- In-home support services
- Leisure, education, recreation and socialization
- Transportation

Through the strategic planning process, these areas of need were honed into seven leading concerns and recommendations. The leading concerns follow:

- Fragmentation among services and lack of a centralized structure for ongoing research, coordinated planning and implementation, and shared accountability within the aging network
- Lack of awareness and underutilization of available services for older adults
- Lack of affordable long-term care options, especially for middle-income seniors
- Need for sustained caregiver supports
- Failure of existing services to account for diversity of the aging population
- Need for increased support for older adult crime victims
- Inadequate transportation services
The 2005 Status of Seniors Initiative Strategic Planning Report presented detailed strategies for addressing these leading concerns and recommendations.

The most recent SOSI report was the Status of Seniors Initiative 2012 Update published in June 2013. The purpose of the update was to evaluate progress in accomplishing the strategic vision outlined in the 2005 SOSI report. In general, the update concluded that progress has been limited, in large part due to lack of funding. The update highlighted five primary areas of unmet need requiring ongoing action:

- Caregiver support
- Transportation
- Housing options for aging in place
- Lifelong planning for retirement
- Development of livable environments

The 2005 SOSI Strategic Planning Report was intended to serve as a call to action for local businesses and organizations to adopt the proposed recommendations and act as change leaders within the community. However, the Charlotte-Mecklenburg Council on Aging (CMCOA) eventually took on responsibility for implementing many of the recommendations. Subsequent funding cuts prevented the CMCOA from continuing its activities. At present, SOSI is inactive.

Overview of Other Relevant Research on the Aging Population
SOSI is the primary source for past research on the needs of local older adults. Several other studies mention the status of older adults and reaffirm the findings of SOSI. The following highlights summarize needs identified in each study:

  - Increased awareness about programs for older adults and better marketing

  - Increased services, facilities, and providers for those with Alzheimer’s Disease

  - Chronic disease management and other health education programs
  - Housing options and services to help older adults age in place
• Expanded public and non-profit transportation services for older adults
• Support services for older adults with mental health issues
• Increased supports for caregivers
• Community education about senior housing and health care options
• Home repair services
• More geriatric health specialists
• Affordable adult day care
• Accessible and affordable home health care

  • More social and fitness programs for seniors

❖ Mecklenburg County Health Department Epidemiology Program. “2013 Mecklenburg County Community Health Assessment.” (December 2013).
  • Initiatives to prevent falls among the elderly
  • Increased resources for treatment and care of those with Alzheimer’s Disease

  • Affordable and accessible housing for older adults
  • Options for aging in place
  • Affordable and accessible health care
  • Assistance with home repairs and maintenance
  • Improved sidewalks and safer streets for vehicles and pedestrians
  • More transportation options
  • Access to a Senior Center
  • Information about available resources

  • Increased awareness about existing affordable housing resources
  • More options to support aging in place
  • Increased awareness about Just1Call
  • Increased coordination between transportation and health care services
  • Improved safety and crime prevention programs
  • Increased civic engagement opportunities such as mentoring/tutoring programs to connect older adults with children

- Injury prevention programs and services for older adults
- Increased awareness of and interventions for low health literacy
Appendix B: Key Informant Interviews

Key Informant Interview Guide

1. What do you think are the greatest needs of older adults in Mecklenburg County?

2. What do you think are the greatest strengths or assets of older adults in Mecklenburg County?

3. Do you see a need for education and advocacy for older adults in our community? If so, what do you think it should look like? If not, why not?

Key Informants

Nancy Carter  
*Mecklenburg Soil and Water Conservation District, Vice Chair*
*Board Member, Charlotte-Mecklenburg Council on Aging*

John Eller  
*Director, Catawba County Social Services*

Jerry Fox  
*Retired Mecklenburg County Manager*
*Community Volunteer*
*Board Member, Charlotte-Mecklenburg Council on Aging*

Maryann Gilmore  
*Community Advocate for Senior Issues*
*Board Member, Charlotte-Mecklenburg Council on Aging*

Mary Anne Hammond  
*Davidson Committee on Aging Chair*

Cynthia Hancock, Ph.D.  
*Senior Lecturer, Undergraduate and Service Learning Coordinator Gerontology Program, UNC Charlotte Department of Sociology*

Lyndall Hare, Ph.D.  
*Gerontologist*
*Aging Specialist and Eldercare Coach*
John Highfill  
*Board Member, Charlotte-Mecklenburg Council on Aging*

Lynn Ivey  
*CEO and Founder, The Ivey Memory Wellness Day Center*
*Board Member, Charlotte-Mecklenburg Council on Aging*

Norman Mitchell, Sr.  
*Former Mecklenburg County Commissioner*

Kristi Multhaup, Ph.D.  
*Professor of Psychology, Davidson College*

Evelyn Newman  
*Board Member, Charlotte-Mecklenburg Council on Aging*

Michael Olender  
*Associate State Director, AARP North Carolina - Charlotte*

Charles Page  
*President, Cool Spring Center*

Trena Palmer  
*Executive Director, Charlotte-Mecklenburg Senior Centers*

Maarten Pennink  
*Community Volunteer*
*Board Member, Charlotte-Mecklenburg Council on Aging*

Don Sanders  
*Board Member, Charlotte-Mecklenburg Council on Aging*

Mike Sullivan  
*50-Plus Communications Consulting*
*Board Member, Charlotte-Mecklenburg Council on Aging*

Jennifer Szakaly, M.A., CMC  
*Geriatric Care Manager*
*Owner, Caregiving Corner, LLC*
Michael Taylor
*Director, Services for Adults Division, Mecklenburg County Department of Social Services*

Gayla Woody
*Former Director, Centralina Area Agency on Aging*
Appendix C: Focus Groups

Focus Group Discussion Guide for Community Members

1. What are your greatest needs?

2. What keeps you from getting these needs met?

3. Has there ever been a time when you had a need and were able to find help to meet that need? If so, what was it that helped you meet your need?

4. If you could change one thing about how older adults are treated or served in Mecklenburg County, what would it be?

5. What is it about aging or being an older adult that you would like to have more information about?

6. What is it about aging or older adults that you would like others in the community have more information about?

7. Has there ever been a time when you needed to advocate for yourself? If so, what did you do? Did you or did you not advocate for yourself? Would an organization with a specific mission of advocating for older adults have been helpful to you in this situation? How so?

8. Is there anything we have not yet talked about that you think we should know about the needs and experiences of older adults?

Focus Group Discussion Guide for Administrators of Older Adult Programs

1. In your role as an administrator or manager, what do you see as the greatest needs of older adults?

2. What do you think keeps older adults from getting these needs met?

3. What do you think helps older adults the most in meeting their needs?
4. If you could change one thing about how older adults are treated or served in Mecklenburg County, what would it be?

5. What is it about aging or older adults that you would like to have more information about?

6. What is it about aging or older adults that you would like others in the community have more information about?

7. Has there ever been a time when you needed to advocate for an older adult? If so, what did you do? Did you or did you not advocate? Would an organization with a specific mission of advocating for older adults have been helpful to you in this situation? How so?

8. Is there anything we have not yet talked about that you think we should know about the needs and experiences of older adults?

Focus Group Discussion Guide for Family Caregivers

1. As a caregiver, what do you see being the greatest needs of those you care for?

2. What are the barriers that keep those you care for from getting their needs met?

3. What are your greatest needs as a caregiver?

4. What helps you the most in meeting your needs as a caregiver?

5. What barriers do you face meeting your own needs?

6. What is most helpful to those you care for?

7. If you could change one thing about how caregivers or those you care for are treated or served in Mecklenburg County, what would it be?

8. Is there anything about caregiving or aging that you would like to have more information about or that you would like the community to know more about?

9. Has there ever been a time when you needed to advocate for someone you were caring for or for yourself as a caregiver? If so, what did you do?
10. Would an organization that advocates for older adults be helpful for you? How so?

11. Is there anything we have not yet talked about that you think we should know about the needs and experiences of caregivers or those you care for?
Appendix D: Glossary of Revenue Source Terminology

All revenue source terminology listed below is directly quoted or paraphrased from the Internal Revenue Service 2013 Instructions for Form 990 Return of Organization Exempt From Income Tax. A complete copy of the instructions is accessible through the following link: http://www.irs.gov/pub/irs-pdf/i990.pdf.

Contributions from Fundraising Events – Refers to “. . . contributions received from fundraising events, which includes, but is not limited to, dinners, auctions, and other events conducted for the sole or primary purpose of raising funds for the organization's exempt activities (p. 37).”

Federated Campaigns – Includes “. . . contributions received indirectly from the public through solicitation campaigns conducted by federated fundraising agencies and similar fundraising organizations (such as from a United Way organization). Federated fundraising agencies normally conduct fundraising campaigns within a single metropolitan area or some part of a particular state, and allocate part of the net proceeds to each participating organization on the basis of the donors' individual designations and other factors (p. 37).”

Income from Fundraising Events – Reflects “. . . the net income from fundraising events, not including the amount of contributions from fundraising events . . . (p. 40).”

Income from Sales of Assets Other Than Inventory – Represents “. . . all sales of securities; . . . sales of all other types of investments (such as real estate, royalty interests, or partnership interests) and all other non-inventory assets (such as program-related investments and fixed assets used by the organization in its related and unrelated activities). . . . [Also includes] capital gains dividends, the organization's share of capital gains and losses from a joint venture, and capital gains distributions from trusts (p. 39).”

Income from Sales of Inventory – Includes “. . . sales of items that are donated to the organization, that the organization makes to sell to others, or that it buys for resale. Sales of inventory do not . . . include the sale of goods related to a fundraising event . . . (p. 41).”

Investment Income – Includes “. . . the gross amount of interest income from savings and temporary cash investments, dividend and interest income from equity and debt
securities (stocks and bonds), amounts received from payments on securities loans, . . . as well as interest from notes and loans receivable (p. 39)."

**Membership Dues** – Includes “. . . membership dues and assessments that represent contributions from the public rather than payments for benefits received or payments from affiliated organizations. . . . Membership dues that are not contributions because they compare reasonably with available benefits are reported . . . [as] Program Service Revenue. Membership dues can consist of both contributions and payment for goods and services. In that case, the portion of the membership dues that is a payment for goods or services should be reported . . . [as] Program Service Revenue. The portion that exceeds the FMV [fair market value] of the goods or services provided should be reported . . . [as contributions]. The portion of membership dues attributable to certain membership benefits that are considered to be insubstantial (for example, low-cost articles, free or discounted admission to the organization's activities, discounts on purchases from the organization’s gift shop, free or discounted parking) may be reported as contributions . . . rather than as payments for goods or services . . . (p. 37)."

**Government Grants** – Includes “. . . contributions in the form of grants or similar payments from local, state, or federal government sources, as well as foreign governments. . . . [T]he payment is recorded . . . [under this classification] if the general public receives the primary and direct benefit from the payment and any benefit to the governmental unit is indirect and insubstantial as compared to the public benefit (p. 37)."

**Other Contributions, Gifts, Grants** – Includes “. . . all other contributions, gifts, and similar amounts the organization received from sources not reported separately . . . [as contributions from federated campaigns, membership dues, fundraising events, government grants, or related organizations]. This amount includes contributions from donor advised funds (unless the sponsoring organization is a related organization) and from gaming activities (p. 38)."

**Program Service Revenue** – Refers to revenue from “[p]rogram services . . . that form the basis of an organization's exemption from tax. . . . Program service revenue includes income earned by the organization for providing a government agency with a service, facility, or product that benefited that government agency directly rather than benefiting the public as a whole. . . . Program service revenue also includes income from program-related investments. These investments are made primarily to accomplish an exempt purpose of the investing organization rather than to produce income. . . . Unrelated trade or business activities (not including any fundraising events or
fundraising activities) that generate fees for services can also be program service activities (p. 38)."

Common types of program service revenue:

- “Medicare and Medicaid payments, and other government payments made to pay or reimburse the organization for medical services provided to individuals who qualify under a government program for the services provided, and who select the service provider (p. 38).”
- “Payments for medical services by patients and their guarantors, and
- Fees and contracts from government agencies for a service, facility, or product that primarily benefited the government agencies (p. 38).”
- Income from program-related investments . . . made primarily to accomplish the organization’s exempt purposes rather than to produce income (p. 38).”
- Membership dues and assessments received that compare reasonably with the membership benefits provided by the organization (p. 39).”

**Rental Income** – Represents the net “. . . rental income received for the year from investment property and any other real property rented by the organization. . . . [Excludes] income related to the filing organization’s exempt function (program service) (p. 39).”