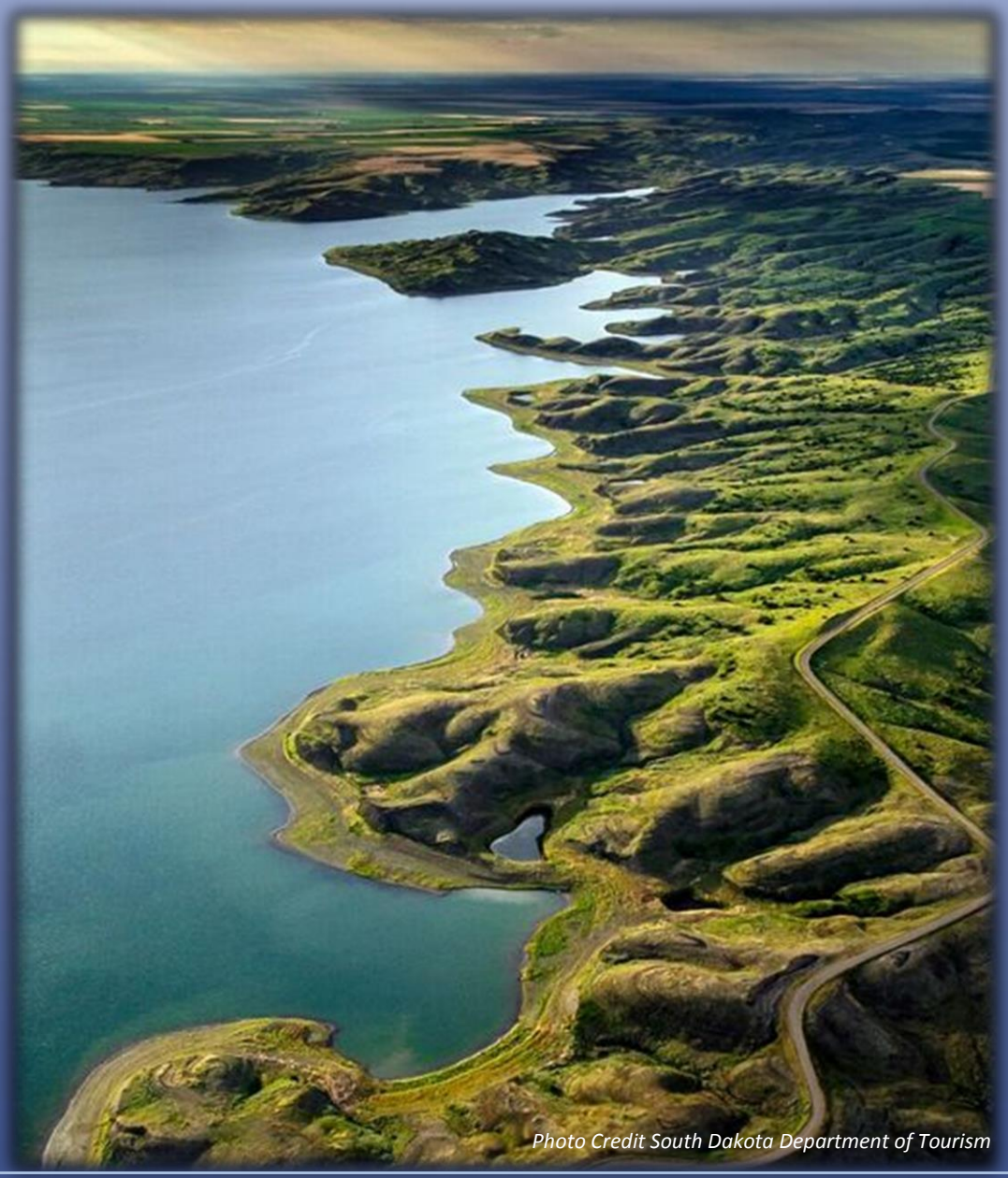

South Dakota State Plan on Aging

Department of Human Services, Division of Long Term Services and Supports

October 1, 2017 – September 30, 2021

A Message from Governor Daugaard

Dear Fellow South Dakotans,

It is my pleasure to present the South Dakota State Plan on Aging for the period of October 1, 2017 through September 30, 2021 as required by the Federal Older Americans Act. The State of South Dakota remains committed to rebalancing the long term services and supports system in South Dakota to allow older individuals and adults with disabilities to remain living at home and in the community for as long as possible.

In order to better serve our older citizens, I signed an Executive Order in January, 2017 to ensure a more integrated approach to long term services and supports delivery in South Dakota. The Order authorized the transfer of the Division of Adult Services and Aging from the Department of Social Services to the Department of Human Services as well as the renaming of the Division to Long Term Services and Supports (LTSS) to better reflect the mission of the Division. The purpose of the reorganization is to create a more integrated approach to the delivery of long term care in South Dakota and to ensure people get the services they need in their communities. This change shifts our focus away from measuring success on the number of services provided and consumers served to understanding how the programs and services impact our consumers. The ultimate goal is to create a better life and higher quality of care for our older citizens.

The Division of Long Term Services and Supports, formerly Adult Services and Aging, and its many partners have routinely gathered comments and ideas statewide about what is needed to best respond to our changing and growing older adult population. Seniors, caregivers, providers of services, Advisory Council on Aging members, workgroups and public officials from across the state responded to our invitation to share their thoughts on the status and future of ensuring seniors have the opportunity to age in place within their communities. They shared their challenges and hopes and we listened. The State Plan on Aging reflects this input and the desire of the Department to develop better ways for South Dakotans to age with dignity.

South Dakota is committed to assuring older citizens and adults with disabilities have access to a service system that provides for their individual needs and preferences and allows them to live longer, healthier and more fulfilled lives in their local communities.

Sincerely,

Dennis Daugaard

Governor of South Dakota

VERIFICATION OF INTENT

South Dakota State Plan on Aging
October 1, 2017 – September 30, 2021

The South Dakota Department of Human Services' Division of Long Term Services and Supports State Plan on Aging is a tool to communicate the authority vested in them to develop and administer the requirements of the Administration on Aging's Older Americans Act provisions.

The Division of Long Term Services and Supports serves as the State Unit on Aging and is designated as the Single Planning and Service Area (PSA) for purposes of administering the funds under the Older Americans Act.

The State Plan on Aging puts forth the State's primary obligation for coordinating all State activities related to the Older Americans Act for the next four years, i.e. the development of comprehensive and coordinated systems for the delivery of supportive services such as adult services and nutrition programs, along with effective preventive health services.

The South Dakota State Plan on Aging is hereby approved by the Governor and the Department of Human Services Cabinet Secretary and has been developed in accordance with the guidance of all federal statutory and regulatory requirements.

(Date)	Yvette Thomas, Director Division of Long Term Services and Supports
(Date)	Gloria Pearson, Cabinet Secretary South Dakota Department of Human Services
(Date)	Dennis Daugaard, Governor State of South Dakota

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EXECUTIVE SUMMARY

As the State Unit on Aging, the South Dakota Division of Long Term Services and Supports (LTSS) within the Department of Human Services (DHS) is responsible to develop, implement and administer a State Plan on Aging in accordance with all Federal statutory and regulatory requirements, including the Older Americans Act (OAA). The Division of LTSS is responsible for coordinating and carrying out all state activities related to the OAA (as amended and reauthorized in 2016) and serving as an effective and visible advocate for older citizens. This State Plan on Aging is effective October 1, 2017 through September 30, 2021, and reflects South Dakota's plan for responding to the continuum of care needs of older citizens and adults with disabilities.

In order to effectively create and design the State Plan on Aging, the Department and its partners have spent the past several years gathering comments and suggestions statewide about what is needed to best respond to our changing and growing older adult population. Seniors, caregivers, service providers, Advisory Council on Aging members, workgroups, and key stakeholders from across the state responded to our invitation to share their thoughts on the status and future of seniors including addressing and identifying the challenges our state is facing in meeting those needs.

During the 2017 Legislative Session, Governor Daugaard signed an Executive Order to ensure a more integrated approach to the long term services and supports delivery in South Dakota. The Order authorized a reorganization of the Department of Social Services' Division of Adult Services and Aging within the Department of Human Services' as an approach for coordinating and providing home and community-based services.

Demographic changes in future years will result in significant increases to the populations we serve. This challenge inspired the Executive Order for reorganization to efficiently and effectively meet the growing needs. Previously, individuals with specific qualifying physical disabilities in need of state assistance with long term services and supports received those services through the Department of Human Services. Individuals with age-related or other qualifying disabilities received assistance from the Department of Social Services. Combining these services into one Department ensures people can best access long term services in their homes and communities, regardless of why they need the services or what type of disability they have. Additionally, this change aligned services available for individuals, and continued development of community-based services benefiting the citizens of South Dakota.

The Department of Human Services, Department of Social Services and Department of Health have been working closely together for several years leading the effort to enhance long term services and supports in South Dakota. Through a series of workgroups and other initiatives, South Dakota has identified challenges facing the state in upcoming years. We have taken, and continue to take steps toward the goal of meeting those challenges. The goals identified in the State Plan address the challenges that South Dakota's State Unit on Aging faces by promoting existing services, improving access to services, enhancing quality of services and empowering the workforce and local community supports. These goals, along with the objectives and strategies, align closely with the vision and expectations of the Older Americans Act and provide a roadmap for the future of South Dakota's older citizens and adults with disabilities.

Context

The South Dakota State Unit on Aging has created a plan to guide the operation of the organization over the course of the next four years. Our vision, values and goals illustrate our commitment to the aging population throughout the state.

Our Vision

The Division of Long Term Services and Supports' vision is to maximize the health, well-being, and quality of life for South Dakotans who are aging or disabled and are in need of services and supports through a person-centered system which encourages and empowers them to live independently with dignity, make their own choices, and participate fully in society.

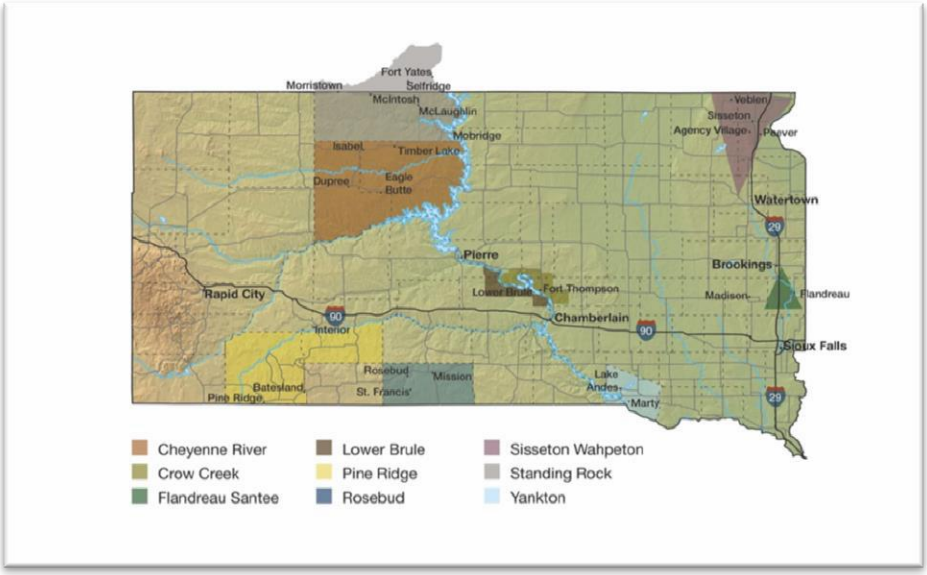
History and Current Status

As a State: South Dakota

South Dakota is designated as a frontier state by the Affordable Care Act. At least 50 percent of the counties in South Dakota are frontier counties where the population per square mile is less than six people. Frontier counties are best described as sparsely populated rural areas that are geographically isolated from population centers and services.

South Dakota has nine federally recognized Native American tribes within its boundaries, which have independent, sovereign relationships with the federal government. The majority of South Dakota's reservations are geographically isolated in frontier locations.

South Dakota's Native American Tribal Locations



[1]

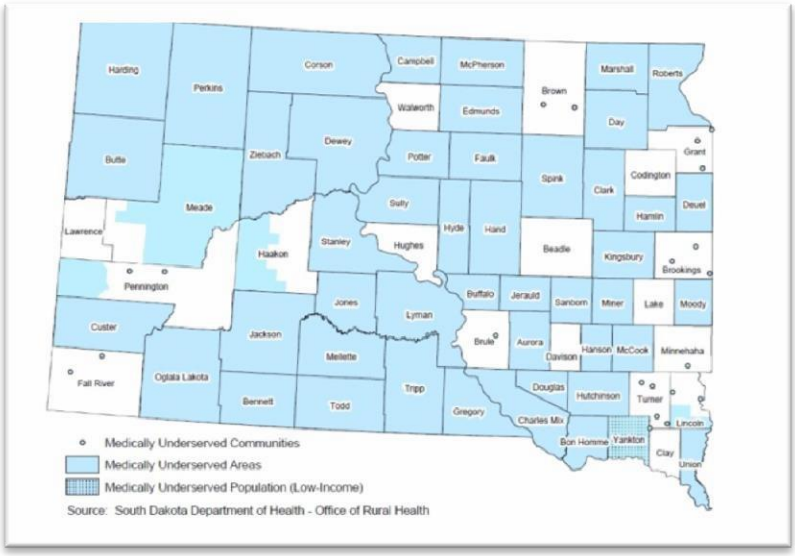
South Dakota's frontier landscape continues to present unique challenges for service delivery. Maintaining a healthcare workforce in rural and frontier communities throughout the state has

[1] http://www.sdtribalrelations.com/maptribes.aspx

proven to be difficult. As of January 2017, 47 of South Dakota's 66 counties were classified as a medically underserved area or population by the South Dakota Department of Health. As a result, healthcare services are often clustered within one community in a region, which can result in individuals traveling long distances to receive needed services. Public transportation is frequently limited or unavailable in rural and frontier areas, making access to healthcare providers even more difficult for individuals living in those areas.

Efforts to rebalance the long term services and supports in South Dakota have been initiated in phases over many years, the most recent dating a study by Abt and associates in 2007, followed by a Long Term Care Taskforce described in more detail in Attachment K, an updated Abt and associates study in 2015 and most recently a LTSS internal workgroup composed of key State staff dedicated to re-energizing the rebalancing efforts.

South Dakota's Medically Underserved Areas/Populations as of January 2017



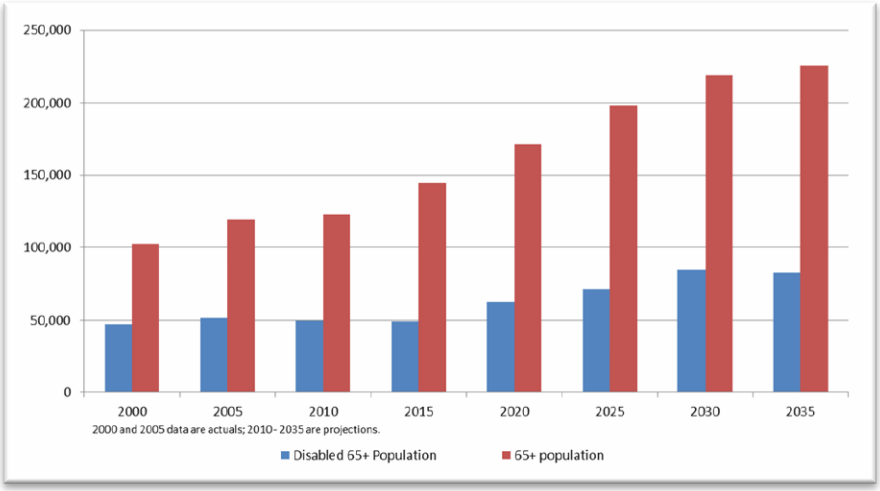
[2]

According to the Abt Associates' analysis [3], see Attachment G, our state will experience demographic changes in the coming years, which will require enhanced long term services and supports to meet the needs of South Dakota citizens. In 2035, it's estimated the number of elders will increase in South Dakota by 84 percent, compared to 2010. The number of elders with disabilities will be 71 percent higher than the 2010 Census total. The following illustrations show the projected population growth of South Dakotans who are elderly and disabled and specific counties where the population is expected to double by 2035.

[2] https://doh.sd.gov/documents/Providers/RuralHealth/MUA.pdf

[3] Abt Associates' analysis of South Dakota Data Center's Population Projections data, 2010 and American Community Survey (revised in 2015)

Projections of South Dakota's Elderly and Disabled Population (2000-2035)



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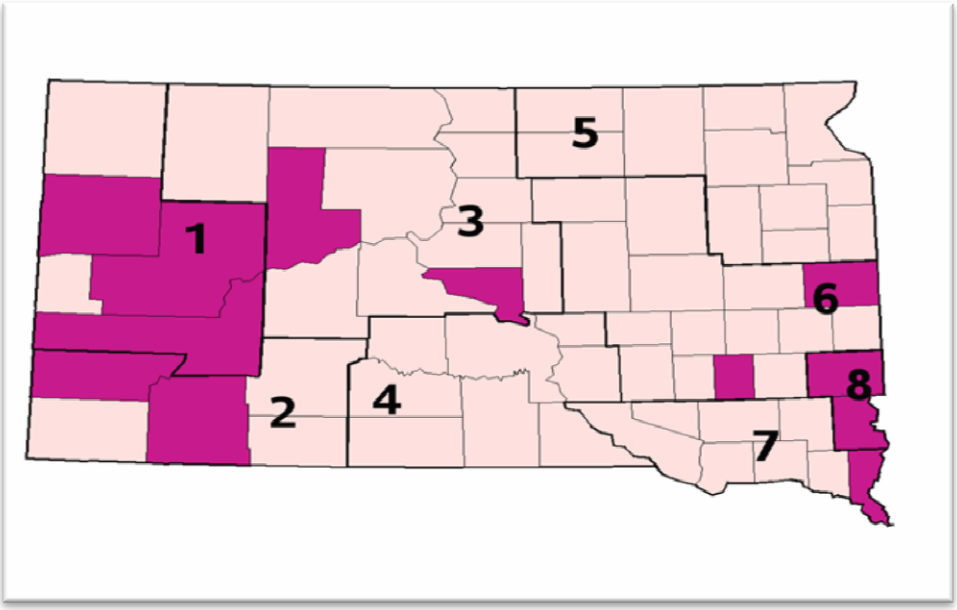
South Dakota Counties Where Elderly Population is Expected to Double from 2010 to 2035 (in Dark Pink)



3

As an Agency: South Dakota Department of Human Services' Division of Long Term Services and Supports

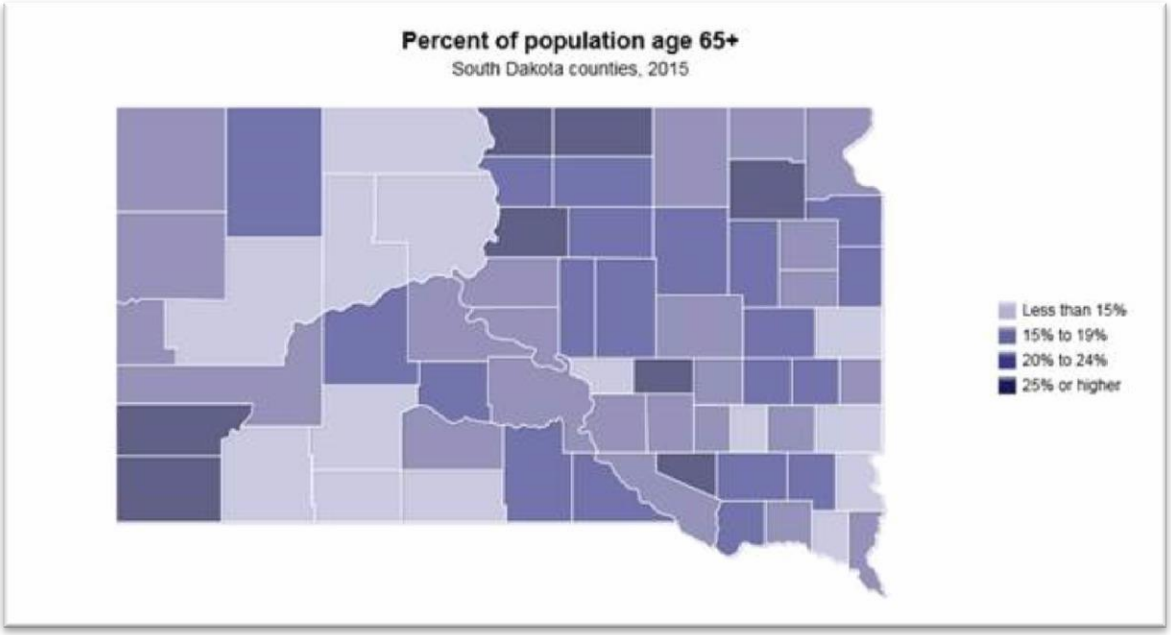
The Division of Long Term Services and Supports within the South Dakota Department of Human Services is the designated single State Unit on Aging providing long term services and support options for elderly South Dakotans and adults with disabilities.

Within the Division of Long Term Services and Supports, the state is divided into 9 regions which encompass 23 fully staffed and 3 itinerate local field offices, 5 Aging and Disability Resource Connections (ADRC) Call Centers, 5 Medical Review Team Nurses and 6 Local Long Term Care Ombudsmen which strategically provide statewide coverage. To staff this major statewide operation, there is a Division Director, Deputy Division Director, 11 Program Specialists and 2 support staff located in the State Office who manage the various programs listed in the Focus Areas of the State Plan. Additionally, local field offices house 57 Specialists, 10 Supervisors, 2 Regional Managers and 4 designated support staff who provide information, assistance and referral services, options planning, needs assessments, case management, care plan development and adult protective services to consumers in their communities.

The first formal program on aging in South Dakota began with the creation of the Governor's Planning Commission for the White House Conference on Aging in 1961. This commission served as the foundation for building a Division within the Department of Social Services dedicated to the unique needs of the elderly population as well as serving adults with disabilities. The Governor's 2017 Executive Order moved this Division to the Department of Human Services.

The first South Dakota Advisory Council on Aging was established in 1968. The Advisory Council is a board of members appointed by the Governor who provide geographical representation throughout the state. The Advisory Council on Aging reviews and evaluates programs and services available in South Dakota and makes recommendations for improving or integrating such activities to benefit older South Dakotans. The Council addresses ways to meet the continuum of care needs and ensures comprehensive representation of South Dakota citizens.

The State Unit on Aging will, in accordance with the Older American's Act, continue to focus on meeting the needs of individuals targeted in the Older Americans Act: individuals with low incomes, individuals with greatest economic need, individuals from minority populations, individuals living in rural areas, individuals with limited English language proficiency and individuals at risk of institutional care.



[4]

Collaboration with Other State Programs

The Department of Human Services is comprised of six services and program areas including the Office of the Secretary, the Division of Developmental Disabilities, the South Dakota Developmental Center, the Division of Rehabilitation Services, the Division of Long Term Services and Supports, and the Division of Service to the Blind and Visually Impaired. The Department of Human Services works collaboratively with the Department of Social Services, including the Division of Medical Services and the Division of Economic Assistance. The Division of Medical Services administers the Medicaid program while the Division of Economic Assistance provides medical, nutritional, financial and case management services to improve the well-being of lower income families, children, people with disabilities and the elderly, as well as determining eligibility for Medicaid long term care services.

[4] U.S. Census Bureau, Decennial Census and Population Estimates
http://factfinder.census.gov

Focus Areas and Programs

The South Dakota State Unit on Aging has created a plan to guide the operation of the organization over the course of the next four years. Our vision, values and goals illustrate our commitment to the aging population throughout the state.

Focus Area A: Older Americans Act (OAA) Core Programs

Supportive Services (Title III-B)

Transportation

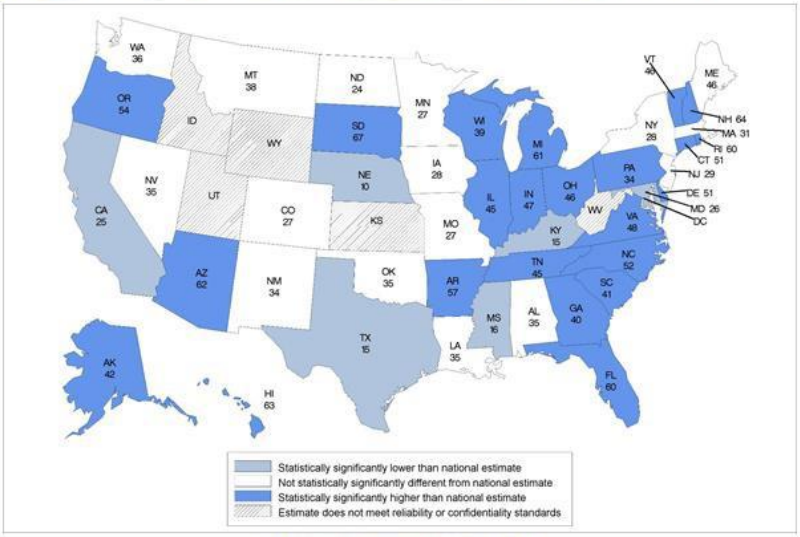
The Division of Long Term Services and Supports works collaboratively with 23 transportation projects either directly or through a partnership with the South Dakota Department of Transportation. Provision of funding for transportation continues to be a cost-effective and valuable service. South Dakota Transportation Services have provided on average 327,121 trips in each of the last four years at a relative cost of $1.71 per ride.

Adult Day

LTSS contracts with 6 Adult Day programs across the state providing an average of 395 hours of service per consumer. The State recognizes the value of adult day services and is committed to working with providers throughout the state to offer this service statewide. As recommended by the LTSS Workgroup, the focus area for the Division of Long Term Services and Supports is to increase the availability and utilization of adult day services across the state. This is recognized as a critically important option to allow caregivers to continue working while also allowing individuals the opportunity to remain living safely in the community. As the elderly population continues to grow, compounded by the increasing rates of Alzheimer's disease, Adult Day services will remain a crucial component of South Dakota's long term services and supports. The following illustrations provide information from the National Study of Long-Term Care Providers of 2014[5] to support our focus on increasing the availability of adult day services statewide to those who need them most.

[5] Centers for Disease Control and Prevention (CDC) and National Center for Health Statistics' (NCHS) National Study of Long-Term Care Providers of 2014

Percentage of adult day services center participants diagnosed with Alzheimer's disease or other dementias: United States, 2014



Statistical significance tested at p<0.05.
Note: The national percentage is 30%.

Source: CDC/NCHS, National Study of Long-Term Care Providers, 2014

5

Nutrition Services (Title III-C)

The Division of Long Term Services and Supports administers the Title III-C Elderly Nutrition Program for the state, distributing funds provided by the Administration on Aging to contracted nutrition providers. These funds continue to be supplemented by state general funds, program income (donations), and required cash match. Through a contractual relationship, nutrition providers are required to give priority for services to rural areas and individuals with greatest economic and social need. Providers also offer nutrition counseling and education related to the improvement of health and nutritional well-being.

LTSS contracts with a registered dietician to prepare menus in compliance with the Food and Nutrition Board of the Institute of Medicine of the National Academy of Science's required minimum of one-third of the recommended daily allowance. Providers may either use the menus provided or contract independently with a dietician to meet the requirements. South Dakota's menus are prepared in a four week cycle and available on the LTSS website.

There are 16 Nutrition Providers located throughout South Dakota. The Division of LTSS contracts with 16 Nutrition Providers operating 200+ meal sites across the state, including sites in counties with some of the lowest income per capita in the nation and sites located on American Indian Reservations. These providers offer both congregate and home delivered meals within their service area. Individuals who are homebound are eligible for home delivered meals. Currently, the number of meals being provided statewide is trending up.

Title VI (Native American Programs)

Tribal governments within South Dakota receive Title VI funding directly from the Administration for Community Living (ACL) to provide meals at sites throughout South Dakota's tribal areas. Additionally, Long Term Services and Supports provides Title III funding to nutrition programs operated by four tribal programs operated by Cheyenne River, Rosebud, Sisseton-Wahpeton and Standing Rock Elderly Nutrition programs to supplement access for individuals living within tribal areas.

LTSS funded programs work collaboratively with tribal programs to provide meals at locations across the state. In many instances, both tribal and LTSS supported programs are operating within the same reservation boundaries, but at different community locations to increase the availability of meals to residents of the reservation lands. LTSS supports the tribal operated programs by listing their meal sites and contact information on the Department website along with the meals programs operated by contracted nutrition programs. LTSS coordinates with ACL as necessary regarding questions about Title VI funded programs, and continues to seek opportunities to improve coordination. LTSS representatives have accompanied ACL staff on site visits to Title VI funded sites to answer questions and provide information on other services provided by LTSS; a practice that will be continued in future years.

LTSS staff have been invited by tribal members to Title VI meal sites on the reservation to provide information and education to tribal members regarding adult protection issues and other services provided by the Division of Long Term Services and Supports. LTSS Specialists will be attending monthly at different locations across the Title VI sites. Additionally, the Division of Long Term Services and Supports has been invited by the Oglala Sioux Tribe to participate as a member of an Elder Protection Team the tribe is working to develop on the Pine Ridge Reservation. The outreach has created an opportunity for interaction and information sharing which is expected to be very beneficial in coordinating services to the Native American tribal areas.

Disease Prevention/Health Promotion (Title III-D)

The impact of chronic disease in South Dakota is a significant focus for LTSS in South Dakota. Chronic disease accounts for decreased quality of life, an increased need for health care services, and consequently a substantial economic impact. The Department of Human Services has a contractual relationship with the South Dakota Department of Health to support Better Choices, Better Health®, a community-led evidence-based program modeled after Stanford University's chronic disease self-management program. The program is supported by the South Dakota Department of Human Services, Department of Health and the South Dakota State University Extension Services.

Research has shown the program is effective based on participant outcomes, such as, individuals will be able to better manage their symptoms; communicate more easily with doctors and their loved ones; be less limited by an illness; spend less time at the doctor or in the hospital; and generally feel better after participating in the six-week workshop. In an effort to increase participation and better reach the rural areas of South Dakota, Better Choices, Better Health® will begin offering an online version of the workshop in 2017.

Better Choices, Better Health® workshops held in community settings such as senior centers, churches, and libraries. Topics include: techniques to deal with frustration, fatigue, isolation, and poor sleep; appropriate exercise for maintaining and improving strength, flexibility, and endurance; medication management; communicating effectively with family, friends, and health professionals; learning how to pace activity and rest; eating well and fun ways to get active. Better Choices, Better Health® currently has 20 active Master Trainers, 52 Lay Leaders, 4

Master Trainer Outreach Ambassadors, and 8 Regional Contacts (North, East, South, West, Central, and Tribal). From October 1, 2015 – September 30, 2016, 31 workshops were offered in 15 different communities statewide and reached 331 South Dakotans who learned tools and strategies to help them manage their chronic conditions. Going forward, LTSS is committed to continue this partnership in order to allow individuals we serve to continue living within their communities and have an enhanced quality of life.

In April 2017 the South Dakota Department of Social Services received a State Targeted Response to the Opioid Crisis (STR) grant that will assist South Dakota in addressing barriers and expanding access to clinically appropriate evidence-based practices for opioid use disorders through activities such as: enhanced emergency response via naloxone distribution to first responders; expanded access to treatment via in-person and telehealth care delivery, including Medication Assisted Treatment options; increased professional competency among physician, prescriber, and treatment providers via training in the areas of prevention and treatment services; and enhanced recovery support services. First steps will include a comprehensive needs assessment and the development of a statewide strategic plan to drive the implementation of prevention, treatment, and enhanced recovery supports.

A South Dakota Alzheimer's and Dementia Work Group State Plan has been formed with the support of a South Dakota Community Foundation Community Innovation Grant, and participation by the Department of Human Services in the workgroup. The work group plans to accomplish the following over the next year; to bring together a diverse group of individuals from across the state who are interested in tackling issues related to Alzheimer's disease and other dementias, identify gaps in care and services, develop a comprehensive plan based on identified need and seek grant funding to help implement key recommendations of the plan across the state.

LTSS staff are encouraged to participate in Alzheimer's awareness events to help spread the word. On June 21, 2017 staff will be participating in "The Longest Day" events across the state to help raise awareness of Alzheimer's disease and related dementias. The Department will be raising awareness by using social media postings on the Department's Twitter and Facebook pages.

Caregiver Program (Title III-E)

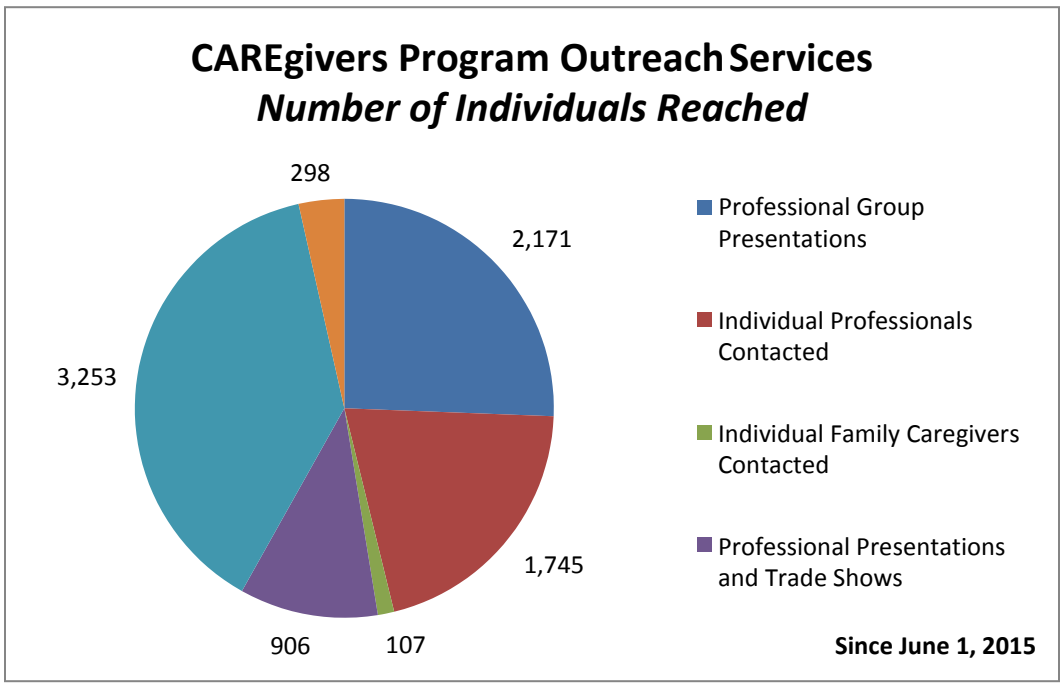
The Caregiver Program in South Dakota provides information and referral, case management, respite, supplemental services, counseling, education, and training to caregivers in support of their efforts to care for family members. The program is uniquely poised to provide services critical to the well-being of caregivers and flexible enough to meet the needs in rural and frontier areas. Integration of the Caregiver Program into the information and referral process implemented under the Aging and Disability Resource Connections (ADRC) has allowed the State Unit on Aging to provide the most appropriate services based on assessed needs.

Staff from the Department of Social Services, Division of Child Protection is encouraged to identify grandparents caring for children who would benefit from funding and services available through the South Dakota Caregiver Program administered by the Division of Long Term Services and Supports and make the referral to a local LTSS Specialist through the ADRC.

The Department of Human Services has a contractual relationship with Active Generations, a senior center located in Sioux Falls, to continue its implementation and administration of a statewide public awareness campaign and series of workshops focused on providing caregiving support, stress management and educational resources in communities across South Dakota. This program is called CAREgivers. While caregiving is often rewarding, family caregivers typically experience stress in a multitude of ways: financial, emotional, social and physical. This

is exacerbated due to the lack of acceptance of their situation, a loved one's diagnosis and lack of education about available resources. The CAREgivers program has observed a pattern of preventive resources not being readily accepted by caregivers and most caregivers only act when faced with a crisis.

In June 2015, the CAREgivers program began a focused campaign to educate caregivers. Since that date they have educated 500 individual caregivers at workshops and 2,390 others through a public marketing campaign and 162 presentations that focus on reducing caregiver fears of asking for help and available resources.

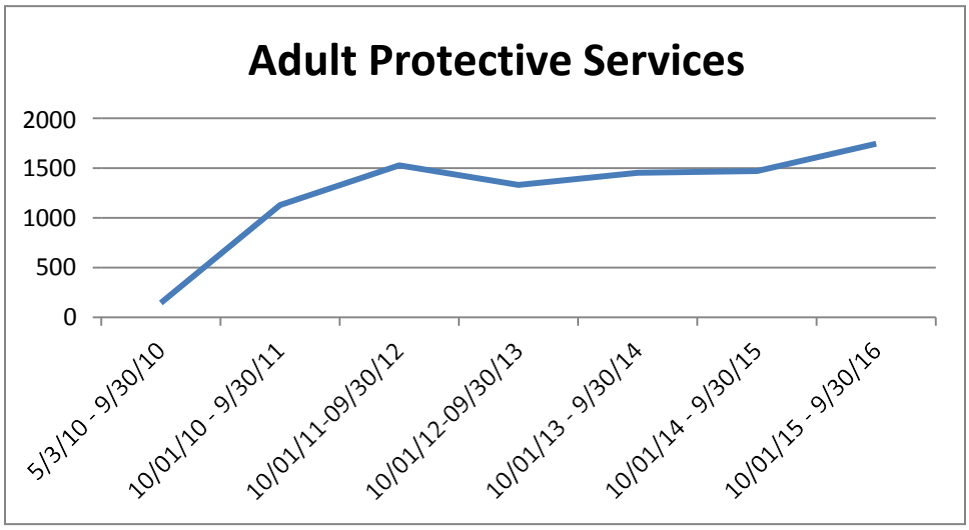


Title VII (Elder Rights Programs)

Adult Protective Services

South Dakota Codified Law 22-46 addresses abuse, neglect or exploitation of elders or adults with disabilities and includes a mandatory reporting component which requires individuals, professionals, employees and entities that have contact with elders and adults with disabilities to report knowledge or reasonable suspicion of abuse, neglect, or exploitation. To report abuse, neglect, or exploitation, these individuals can contact their local law enforcement agency, local state's attorney's office or the nearest LTSS office. A mandatory reporter who knowingly fails to make the required report is guilty of a Class 1 misdemeanor. In addition, any individual who knows or has reason to suspect an elder or an adult with a disability has been or is being abused, neglected, or exploited may voluntarily report that information. Individuals who, in good faith, make a report of abuse, neglect, or exploitation of an elder or an adult with a disability are immune from liability.

LTSS Specialists in local field offices function as Adult Protective Services Specialists, responding to and investigating reports of elder abuse, neglect or exploitation in the community. Reports are received from sources, including but not limited to the following: financial institutions, family members, concerned citizens, medical professionals, and community support providers. Depending on the situation, the Specialists involve others, including: family members, law enforcement, Department of Health, Social Security Administration, and/or the Medicaid Fraud Control Unit of the South Dakota Attorney General's Office. Complaints are documented with the nature of the complaint, results of the investigation and resolution in a centrally maintained database. Adult protective services records are confidential per state statute. Complainants are offered a letter of acknowledgment regarding their report, but are not advised on whether an investigation occurred or on the results of the investigation.



Long Term Care Ombudsman

Pursuant to requirements detailed in the Ombudsman Final Rule of 2015, LTSS underwent a major reorganization of the Long Term Care Ombudsman program in South Dakota. Previously, in addition to the State Long Term Care Ombudsman and two designated local

Ombudsman, the remainder of LTSS field staff served as local ombudsman on a part time basis. Recognizing the benefits of creating separation in duties and increased focus for staff, six Local Long Term Care Ombudsman regions were created across the state and staff positions were created to serve the designated areas. Staff positions were opened for interview and hire in each area; ultimately all positions were filled by existing LTSS staff who had expressed a special interest in providing this service. The reorganization effort has greatly improved the continuity of services and documentation within the program.

Currently, the Long Term Care Ombudsman Program operates in South Dakota utilizing a centralized network approach which includes the State Long Term Care Ombudsman (SLTCO) and 6 Local Long Term Care Ombudsmen (LLTCO) located throughout the state. The Ombudsmen advocate for and protect the rights of individuals residing in nursing facilities, assisted living centers, registered residential living centers, and adult foster care homes. The SLTCO and the Legal Services Developer collaborate on Elder Rights concerns throughout the state.

The reorganization of the Ombudsman Program has enhanced the ability of the program to maintain a presence in long term care facilities through routine on site visits to facilities as well as unscheduled visits prompted by complaint investigations. This is a crucial service as Ombudsmen may be the only connection many residents have to an individual who is not a paid care provider. They work to make sure the rights of residents are upheld. The Ombudsmen use a person-centered approach and work to empower individuals and families to expect excellence.

The Long Term Care Ombudsman Program is further addressed in Focus Area D.

Focus Area B: ACL Discretionary Grants

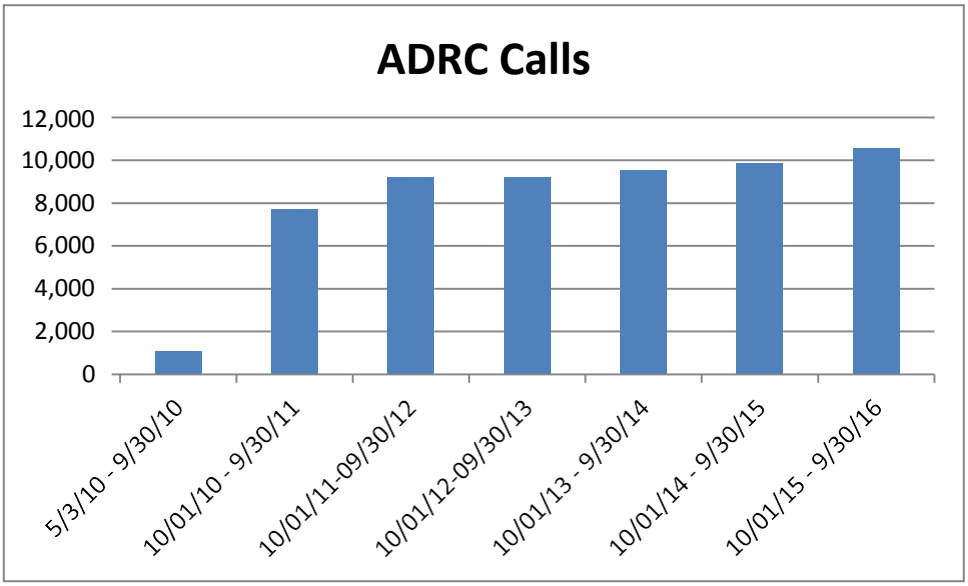
Aging and Disability Resource Center Discretionary Grant

In South Dakota, the Aging and Disability Resource Connections (ADRC) is the single point of entry for older adults, adults with disabilities, caregivers, family members and friends to learn about the long term services and supports available in the state. Through the ADRC, individuals can access both public and nonpublic services and supports that are available as well as plan for the future. By accessing these long term services and supports, individuals can continue to live at home and in the community as long as possible, and as an alternative to moving into facility-based care. In 2013, the State of South Dakota was awarded a one year ADRC Options Counseling discretionary grant. In utilizing this grant, the State Unit on Aging strengthened the capacity of the Aging and Disability Resource Connections (ADRC) by offering Options Planning as a free service, offering information and decision support to all individuals, regardless of age, disability, or income.

A Critical Pathways Workgroup, which included state staff and local providers, finalized an Options Planning Hospital Discharge Referral Protocol and an Options Planning brochure. In addition, ADRC Resource Folders were created and distributed to hospital discharge planners, nursing facilities and providers across the state. The folders contain information on a variety of home and community-based services available to adults over age 60 and adults over age 18 with disabilities.

Outcomes include: 1) individuals have increased access to information on their options for long term services and supports; 2) individuals are provided with options planning upon request; 3)

critical pathway providers refer individuals to the ADRC for options planning; and 4) home and community-based services are utilized through options planning. Options planning ties together systems change efforts began by South Dakota in 2009 through the ADRC by involving critical pathway partners in continued development of a viable and sustainable system of long term services and supports.



In February 2017, the Department issued a Request for Proposal for a Long Term Services and Supports awareness campaign. This will be used to develop print materials, a social media campaign and other marketing strategies. The purpose of this campaign is to improve public education and awareness of the State Long-Term Services & Supports and to rebrand the services South Dakotans can access through the ADRC.

The target audiences are older adults and adults with physical disabilities and their family member and other caregivers. The message will include the availability and benefits of services available now and information on how to plan for the future, living at home and in the community with services and supports for as long as possible and as an alternative to moving into facility based care.

The successful offeror will produce materials highlighting the availability of a continuum of services including home and community based services with the goal of serving people in the most integrated setting available to meet their need. The successful offeror will work collaboratively with the State staff on creative development of advertising concepts, messages, themes, slogans and social and digital media using a high quality photo collection which is South Dakota specific.

Money Follows the Person Discretionary Grant

Money Follows the Person (MFP), located within the Department of Social Services, Division of Medical Services, coordinates with the ADRC to help people living in nursing homes, hospitals, or intermediate care facilities and those with intellectual and developmental disabilities successfully return to their communities. The program helps people identify barriers to living on their own and provides one-time transition support helping people find a place to live that meets

their needs as well as ongoing service support to help them find the services they need to keep living there. The State of South Dakota continues to integrate activities between MFP and ADRC to best serve consumers and provide a wide array of choices and opportunities for long term services and supports. MFP will be an important partner in transitioning individuals from long term care settings into their communities as a part of the overall rebalancing efforts.

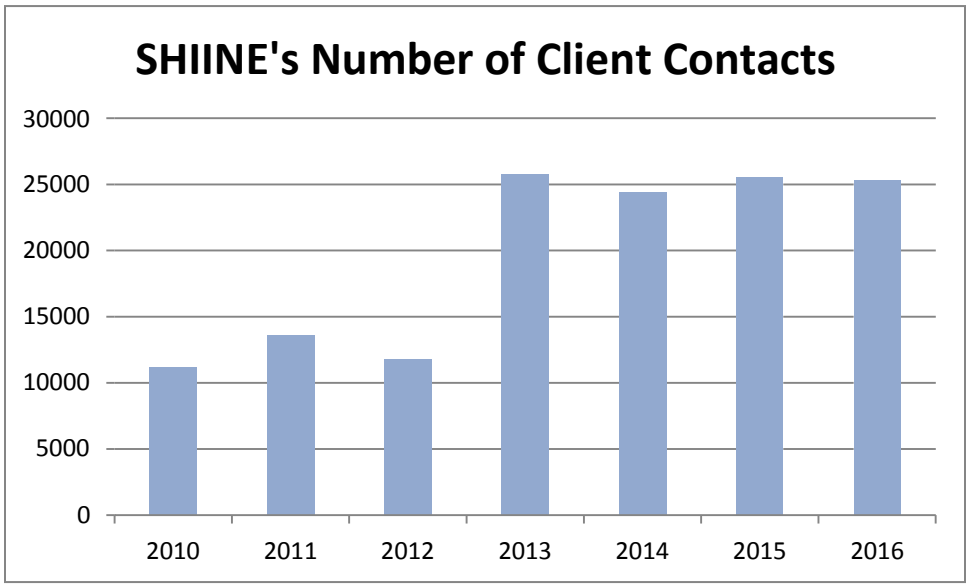
State Health Insurance Assistance Program (SHIP), Senior Medicare Patrol (SMP) and Medicare Improvements for Patients and Providers Act (MIPPA) Discretionary Grant

South Dakota's Senior Health Information and Insurance Education (SHIINE) program is a volunteer program comprised of three regional offices funded collectively by the Administration for Community Living with the State Health Insurance Assistance Program (SHIP), Senior Medicare Patrol (SMP) and Medicare Improvements for Patients and Providers Act (MIPPA) grants. SHIINE's mission is to empower and assist Medicare beneficiaries, their families, and caregivers by providing free, in depth, one-on-one insurance counseling and assistance and educating them on how to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education.

The SMP grant was applied for and awarded in June 2015. The addition of this grant opportunity has served to strengthen the SHIINE presence and credibility. SHIINE has a statewide network of 430 volunteers and program partners who are trained to provide free, objective, and local one-on-one health insurance counseling and assistance to Medicare beneficiaries and their families.

The primary role of the SHIINE program is to provide outreach and education to people with Medicare and others regarding health insurance options, benefits, choices and avoiding, detecting, and preventing health care fraud. In doing so, SHIINE helps educate and protect individuals with disabilities and the aging population, promoting integrity of the Medicare program and helping low-income Medicare beneficiaries apply for programs that make Medicare affordable. A comprehensive set of risk and program management policies guide the operation of the SHIINE volunteer program focusing on program growth, accountability, adaptability and awareness of volunteer program risks.

Over the past three years the South Dakota SHIINE program's performance measures score ranked within the top 3 out of 54 states and territories in the nation. In 2016, SHIINE served 25,309 individuals and saved those individuals$3.4 million. Most of the credit for SHIINE's success rests with its core of committed volunteer counselors throughout the state.



Focus Area C: Participant-Directed/Person-Centered Planning

The State Unit on Aging is committed to the further development of person centered programing. A person-centered approach will continue to be used to provide three main functions through the Aging and Disability Resource Connections: 1) information and awareness through education and information on long-term services and supports options; 2) assistance through long term support options planning, referral, crisis intervention, and planning for future needs; and 3) access through pre-eligibility screening for public pay services, comprehensive assessment and access to private pay services. Several variations of person-centered decision-making tools have been implemented to assist consumers with making important life decisions.

In 2016, the care plan utilized for consumer services was revised and is described as a written person-centered plan developed by the Long Term Services and Supports Specialist along with the consumer, the provider, as well as any individuals the consumer chooses. The Care Plan reflects the services and supports that are important for the individual to meet the needs identified through an assessment of need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

A recognized benefit of the departmental reorganization is that in moving LTSS to the Department of Human Services (DHS) not only will similar services be located within the same agency, the Division of LTSS will also benefit from the staff and agency experience of other DHS Divisions which have been working under a person-centered approach for a number of years. All staff will participate in a two day person-centered thinking training within the first few months of the transition and will continue to incorporate person-centered thinking into their daily work as a part of the movement to becoming a person centered organization.

Ongoing education and training is provided to LTSS Specialists to help them identify consumers who may benefit from options planning and to link them to additional resources and information. In addition, self-assessment tools will remain available to the public via the Department's website.

Focus Area D: Elder Justice

Elder Abuse Task Force

An Elder Abuse Task Force was created during the 2015 legislative session in response to the recommendation of South Dakota Chief Justice David Gilbertson. The Task Force was created to study the prevalence and impact of elder abuse in South Dakota and to make recommendations on policies and legislation to effectively address the issue. In December 2015, the Elder Abuse Task Force Final Report and Recommendations, Attachment J, was released with sixteen recommendations for strengthening state law and policy to combat elder abuse, neglect, and exploitation. Specifically, the Task Force recommended, and the Legislature appropriated funds for an attorney-specialist within the Office of the Attorney General to prosecute, or to assist state's attorneys in prosecuting, the abuse, neglect, and financial exploitation of elders or adults with disabilities. The attorney-specialist also serves as an educational resource and liaison for local and tribal law enforcement. The Task Force also recommended, and the Legislature appropriated funds for an investigator specializing in these cases to assist the attorney in bringing criminal charges and providing education on this topic.

When an Adult Protective Service referral is received intake staff make a preliminary assessment resulting in either follow-up being provided by LTSS specialists or a referral to the Office of the Attorney General or both. The structure created by the Elder Abuse Task Force has resulted in several successful prosecutions of individuals involved in abuse, neglect or exploitation targeted at individuals who are elderly or are adults with disabilities.

Legal Assistance

The Division of Long Term Services and Supports contracts with two agencies to provide legal assistance to South Dakota's elderly citizens at locations throughout the state, including several locations on tribal lands. These agencies have agreed to provide services in accordance with the rules of the Older Americans Act. The Division also employs an individual to serve as the Legal Assistance Developer. This position oversees the legal services contracts and works to build the full functionality of legal services by coordinating provision of legal assistance, working with the Long Term Care Ombudsman Program on elder rights issues, promoting state capacity to offer financial management information to elders, assisting older individuals to understand their rights and maintaining the rights of elderly citizens in the state.

Long Term Care Ombudsman

As previously mentioned in Focus Area A, the State of South Dakota operates the Long Term Care Ombudsman Program by utilizing a centralized network approach which includes the State Long Term Care Ombudsman (SLTCO) and 6 Local Long Term Care Ombudsmen (LLTCO) located throughout the State. The Local Long Term Care Ombudsman Program (LTCOP) advocates for and protects the rights of individuals residing in nursing facilities, assisted living centers, registered residential living centers, and adult foster care homes.

The SLTCO, located in the State Office, oversees the program. The SLTCO maintains records of complaints and concerns in the OmbudsManager database and is responsible for completing the National Ombudsman Report. The SLTCO utilizes the National Ombudsman Resource Center to maximize efforts of the program. This position is also responsible for preparation, coordination, oversight and delivery of educational programs to residents, staff, and the general public regarding Ombudsman issues, elder rights, and culture change in long term care facilities. The six LLTCO are located across the state serving as direct advocates for residents

of long term care facilities in both general terms and in situations where a complaint arises with facility administration or staff. The LLTCO utilize the OmbudsManager data base to document their daily activities including but not limited to cases, community education, complaint and non-complaint visitations, consultations to facilities, information to individuals and survey participation.

The Ombudsman Program maintains a presence in long term care facilities through routine on site visits to facilities as well as unscheduled visits prompted by complaint investigations, attendance at the Department of Health's Office of Licensure and Certification compliance surveys, community and staff education, care conferences, and participation in resident and family council meetings when invited to attend. The Ombudsman Program is crucial as Ombudsmen may be the only connection many residents have to an individual who is not a paid care provider; they work to make sure the rights of residents are upheld. The LTCOP routinely visit with individuals about their short and long term goals including their desires to return to the community. The LTCOP assists individuals in making referrals to the appropriate ADRC Call Centers when it is identified that the individual is interested in returning to the community. The Ombudsmen are focused on person-centered care and work to empower individuals and families to expect excellence while in facilities.

Assessing Our Needs

The South Dakota State Unit on Aging is devoted to providing citizens with the services needed to remain in the community. To ensure service availability, the requests of our consumers and stakeholders were considered. Based on consumer and stakeholder suggestions, improvements to current available services were made in 2016, while plans are currently being developed to implement additional home and community based supports and services in 2018.

Seeking Input, Conclusions and Adjustments

In order to effectively create and design this State Plan on Aging, the Department sought comments and requested input and feedback from a multitude of sources. Input sources included consumers and key stakeholders such as government agencies, long term care providers, home and community-based services providers, legislators, Tribal offices, the Advisory Council on Aging members, the South Dakota Health Care Association, the South Dakota Association of Healthcare Organizations, the Assisted Living Association of South Dakota, the American Association of Retired Persons, and the South Dakota Nutrition Association.

In 2015, Abt Associates of Cambridge, Massachusetts updated the Long Term Care Study, Attachment G, originally completed in 2007, and concluded that the State must maintain its focus on rebalancing the long term services and supports system through: 1) continuing to utilize options planning through the ADRC to educate consumers and families about community-based care alternatives, in attempts to reduce nursing home admissions; 2) continuing to expand and enhance the availability of home and community-based services and potentially State Plan-funded community-based care; and 3) exploration of the care preferences and knowledge base of elders and their caregivers, as well as gathering more information on the informal support networks people are utilizing in lieu of seeking assistance from state programs.

To further explore the needs of South Dakota's citizens, LTSS surveyed and sought input from the public during outreach events and through a statewide distribution of a consumer survey. The consumer survey took place in July 2015 and revealed that 39% of respondents reported they were not currently receiving services designed to assist with the completion of daily living activities. This response could be due to a number of reasons including but not limited to; truly not needing services to remain at home, lacking awareness of services available to support them in staying home and increasing their health and safety, and reluctance to access public services at this time. Almost 28% of these individuals indicated that at least one service listed would help them remain in their home. For the 61% of survey respondents who indicated they were receiving services, the results showed that 51% receive household assistance such as vacuuming, doing dishes, cooking, laundry, and shopping; 24% get rides they need to appointments and community events; 24% receive nursing services for managing medications, monitoring health statuses, conducting physical assessments and providing routine care; and 20% benefit from personal care services such as bathing or dressing. Services provided were supported through Department programs, paid privately, or by informal supports through family and friends. When individuals receiving services were asked if they could remain at home without their current services, the majority (79%) responded they could not, or that they were unsure. The results of the consumer survey response reflect a need for enhanced awareness of the supports that enable a person to remain safely and happily in their own home long term.

The results of this survey were utilized to develop the next steps for the Long Term Services and Supports Home and Community-Based Services (LTSS HCBS) Workgroup. This Workgroup focused on rebalancing the long term services and supports system across the continuum of care. Identified goals of this workgroup were to evaluate barriers to Medicare skilled home health utilization and increase availability of home and community-based services and supports. Stakeholders including in-home providers, long term care providers, government agencies, representatives of South Dakota Association of Healthcare Organizations, South Dakota Health Care Association, Advisory Council on Aging, legislators, and other interested parties met multiple times to provide input. All of the input gathered was considered while developing the State Plan on Aging including; identifying service needs, determining awareness of services offered, and verifying what supports consumers were currently utilizing. Additionally, LTSS providers were surveyed to determine additional services that would be the most helpful for the individuals they support to remain in the least restrictive environment possible.

The LTSS HCBS Workgroup resulted in four recommendations. One recommendation was to provide education and training to health care practitioners regarding reimbursement availability for physician oversight of Medicare skilled home health services and support and education on the reimbursement request process. A second recommendation of the Workgroup was to conduct additional research, including fiscal impact of expanding Home and Community-Based waiver services to include day habilitation, vehicle modifications, non-medical transportation, assistive technology, community transition services, chore services, and training and counseling services related to live in caregivers. In order to further analyze these suggested services and determine how to prioritize implementation, in-home providers and state staff completed a survey. The surveys resulted in many of those services being added to the HCBS Waiver in 2016 and are focuses of South Dakota's State Plan on Aging. The third recommendation of the Workgroup was to enhance awareness and understanding of the ADRC process through additional presentations, education and a public awareness campaign. The final recommendation of the Workgroup was to review the current ADRC process, and work with home health providers and targeted consumer groups to ensure smooth transitions for individuals between hospital and home using the ADRC Hospital Discharge Referral Protocol document and communicating hospitalizations of LTSS consumers to LTSS. As a result of an

internal LTSS workgroup initiated in 2016 a Request for Proposals was issued for an entity to conduct a public awareness campaign and rebranding of ADRC.

All information collected on current and potential services were shared with the LTSS Advisory Council on Aging members. Information about the meetings is posted online as well as in locations where meetings are held prior to each meeting. The public is welcome to attend and provide comments and recommendations for future planning. The Advisory Council expressed appreciation for the direction the state is taking to best meet the needs of South Dakota's elderly population.

The Department convened an internal State Plan on Aging workgroup consisting of the Director, Deputy Director, and Program Specialists of Long Term Services and Supports. The Program Specialists are located in Pierre and are responsible for providing technical assistance to regional staff to ensure programs operate within set standards and services are delivered effectively and efficiently across the state. Additionally, local Long Term Services and Supports Specialists, Supervisors and Regional Managers provided input and feedback regarding ways the State of South Dakota can fulfill the needs of older adults and adults with physical disabilities.

During the spring of 2016, the State of South Dakota convened an internal Long-Term Services and Supports Enhancement Workgroup to focus on the need to re-evaluate South Dakota's long-term services and supports system. Staff in the Department of Human Services, Department of Social Services and Department of Health held regular meetings to enhance and expand home and community-based services options, which will reduce the need for institutional services. The workgroup included leadership, program specialists, supervisors, and regional managers to provide input. The outcome of the internal workgroup was the creation of eight focus areas of concentration toward the goal of rebalancing long term services and supports. Those goal areas are: 1) Expand access to home and community based services by removing barriers created by service limitation in a manner consistent with beneficiary needs and state budget requirements; 2) Transition: Identify and assist people interested in transitioning out from facility based care to community living; 3) Diversion: Implement coordinated diversion efforts to identify individuals at risk for premature admission to facility based care and offer alternative strategies and supports; 4) Establishment of person-centered, conflict-free case management for Medicaid waiver recipients; 5) Expand access to self-directed services for Medicaid waiver recipients; 6) Improve supports to family Caregivers; 7) Develop a new, small family-based residential model as an alternate option for all populations; and 8) Create and implement a public awareness campaign to increase public knowledge of home and community based options for long term services and supports and strengthen the awareness of the Aging and Disability Resource Connections resources.

In preparation for this State Plan on Aging, the Division of Long Term Services and Supports also sought public comment by posting the State Plan on Aging on the Department's website and the public was encouraged to provide comments and suggestions for future planning. A formal public hearing was held on April 24, 2017 followed by an opportunity for public comment until May 24, 2017. All comments were responded to and the State Plan on Aging was submitted to ACL. All recommendations received from the various entities listed above were taken into consideration and incorporated into the State Plan on Aging as appropriate.

Attachment K of the Plan provides detailed information regarding the research and development of the Plan to gather a wide variety of input to discover solutions that ensure older or disabled

South Dakotans have choices, receive services in the most integrated and least restrictive community setting and see meaningful outcomes.

Both nationally reported studies and the Abt and Associates study commissioned by the State indicates that nursing facility utilization in South Dakota is trending down but still remains above the national average. More importantly, HCBS services have not increased at the level necessary to indicate the infrastructure is sufficient to support future growth and needs of the aging population. Consequently, the Division of Long Term Services and Supports will continue its efforts to enhance home and community based services in the coming years, specifically by increasing the amount of services available as well as enhancing provider capacity to allow more individuals the opportunity to receive comprehensive services in the community of their choosing. These efforts will continue through both the internal LTSS workgroup established in 2016 and the implementation of a LTSS Stakeholder work group. LTSS has developed a timeline and invited participants to a stakeholder workgroup intended to help guide a more integrated approach to long term services and supports delivery in South Dakota and develop goals and outcome measurements to evaluate progress. The task force will meet quarterly over the course of a year and is tasked with developing goals for the long term services and supports system in the state. They may also help identify gaps in services and solutions to fill those gaps. The stakeholder work group will consist of members from provider groups to include homemaker and nursing services providers, nursing home providers, assisted living providers, independent living center providers, an Aging Council representative, representatives from advocacy and provider organizations such as South Dakota Association of Healthcare Organizations (SDAHO) and South Dakota Healthcare Association (SDHCA), as well as State Legislators and South Dakota government agency staff.

All of the aforementioned information was considered while developing the following Goals, Objectives and Strategies for South Dakota's State Plan on Aging.

Planning for the Future

After reflecting on the LTSS assessments, surveys, and workgroup findings we have identified challenges as we look ahead as a Division. The adaptations we have made and the commitment to our staff, consumers, partners, and service providers is illustrated through four goals, each supported by objectives, strategies, and performance measures.

GOAL 1: PROMOTE EXISTING SERVICES

South Dakota's State Unit on Aging (SUA) works to ensure services reach individuals who need them most; many are unaware of the services they qualify for and would benefit from. The SUA will expand promotion and outreach efforts to reach more consumers, especially those in the greatest need or in under-served populations.

OBJECTIVE 1.1

Increase education and awareness of long-term services and supports available to older adults and adults with physical disabilities.

STRATEGIES

Promote long term services and supports across South Dakota, concentrating efforts toward low income older individuals, those with limited English proficiency and residents living in rural areas, including individuals on tribal reservations, to better serve all populations.

Rebrand the ADRC and create a public awareness campaign to improve public education and awareness of available long term services and supports.

Collaborate with organizations representing diverse communities to promote long term services and supports.

Develop and update publications to reach public and nonpublic populations.

Redefine and rebrand services to enhance consumer understanding.

Expand ADRC partner collaboration.

Initiate conversations with nursing facility residents within 90 days of admission to discuss the possibility of returning to the community with services and supports

Enhance collaboration with hospital discharge planners to provide education and awareness of home and community based services and supports with a goal of increasing hospital discharges into the community, whenever possible.

OBJECTIVE 1.2

Increase awareness of SHIINE's health insurance counseling, services and education on fraud, waste and abuse available to all Medicare beneficiaries.

STRATEGIES

Ensure SHIINE is aligned with the lifestyle and technology use of newly eligible Medicare beneficiaries.

Increase the number of trained SHIINE volunteers and partners through recruitment and training to serve targeted populations.

Expand SHIINE services across rural, ethnic, culturally diverse and low income communities.

OBJECTIVE 1.3

Target outreach to increase enrollment in Medicare Part D and the Low Income Subsidy benefit to eligible individuals.

STRATEGIES

Evaluate Centers for Medicare and Medicaid Services (CMS) data to focus outreach on the Medicare Part D and Low Income Subsidy benefit-eligible but unenrolled individuals.

Provide outreach on the Low Income Subsidy benefit to low income older individuals, those with limited English proficiency and residents in rural areas including individuals on tribal reservations.

OBJECTIVE 1.4

Increase awareness of protective services and referral procedures by enhancing collaborations with federal, state, and local agencies.

STRATEGIES

Expand and improve collaborations with local law enforcement, financial institutions and community partners to better protect South Dakota's elderly population.

Develop and implement protective services education and materials for LTSS staff based on national standards and minimum recommendations.

Provide community education through outreach events.

Collaborate with the Long-Term Care Ombudsman Program to provide abuse, neglect and exploitation training and education to Long-Term Care facility staff.

OBJECTIVE 1.5

Increase awareness of the Senior Meals program.

STRATEGIES

Provide outreach to rural, ethnic, culturally diverse and low income communities to increase the number of meal participants.

Expand the areas of service by creating or expanding sites to reach low income older individuals, those with limited English proficiency and residents in rural areas including individuals on tribal reservations.

Develop a customer-centered approach to foster growth at sites by focusing on the community atmosphere, updating menu options and incorporating community events.

GOAL 1: PERFORMANCE MEASURES

Increase number of outreach activities and individuals reached.

Increase in trained SHIINE volunteers and partners.

Increase number of SHIINE Ambassadors in rural, ethnic, culturally diverse and low income communities.

Percent increase in SHIINE client contacts to beneficiaries and their caregivers.

Percent increase in Low Income Subsidy benefit enrollment through the SHIINE program.

Increase in referrals to the Federal Office of Inspector General for cases of fraud, waste and abuse from SHIINE staff, volunteers and partners.

Increase presentations about abuse, neglect and exploitation to Long-Term Care facility staff.

Percent increase in number of participants in the Senior Meals program.

GOAL 2: IMPROVE ACCESS TO SERVICES

Consumers often encounter barriers which prevent them from obtaining the services they need. South Dakota's SUA will make services more accessible by expanding utilization of the ADRC Call Centers, improving access to the Long-Term Care Ombudsman Program, Caregiver Services, Adult Day Services, transportation and collaborating with key stakeholders.

OBJECTIVE 2.1

Promote the ADRC Call Centers as the single point of entry for all aging and disability services at the state and local level.

STRATEGIES

Engage with local and state community partners to promote the ADRC as the single point of entry to access person-centered long term services and supports in South Dakota.

Promote the ADRC Resource Directory as an access point for information on available long term services and supports, providers and resources.

OBJECTIVE 2.2

Improve access to Long-Term Care (LTC) Ombudsman services for residents and their families.

STRATEGIES

Continue regular advocacy visits in nursing homes and increase the rate of regular Long-Term Care (LTC) Ombudsman visitation to assisted living facilities.

Provide enhanced training and tools to local LTC Ombudsman to ease documentation and data collection requirements and improve the consistency of data captured at facility visits.

Encourage resident and family participation in their respective council meetings.

Collaborate with other LTC Ombudsman stakeholders to identify facilities in need of increased visits.

OBJECTIVE 2.3

Improve access to adult day service providers.

STRATEGIES

Foster development of additional adult day service providers across the state.

Promote the services and benefits of adult day service providers.

Collaborate with local organizations to support the growth in capacity of adult day service providers.

OBJECTIVE 2.4

Enhance person-centered planning to enable individuals to age in place.

STRATEGIES

Educate hospital discharge planners on long term services and supports available within the state and in their local communities.

Provide training to partners on person-centered thinking to integrate long-term services and supports into the person–centered planning process.

OBJECTIVE 2.5

Improve transportation resources by collaborating with state and local government entities.

STRATEGIES

Advocate on behalf of the older adults and adults with physical disabilities most likely to have limited access to transportation.

Collaborate with state and local governments to facilitate the exchange of information regarding transportation resources.

Further explore adding transportation as a Waiver covered service.

OBJECTIVE 2.6

Enhance relationships with LTSS home health providers to increase access to services for LTSS consumers.

STRATEGIES

Provide education and training to home health providers.

Foster expansion of home health provider staffing and capacity across the state, especially in rural and tribal areas.

Invite home health providers to participate in a stakeholder workgroup to develop strategies for enhancing provider capacity.

GOAL 2: PERFORMANCE MEASURES

Increase utilization of ADRC Resource Directory.

Increase in calls received by the ADRC Call Center.

Increase LTC Ombudsman participation in community education activities.

Increase LTC Ombudsman visitations to facilities.

Percent increase in number of adult day enrollees.

Increase number of trainings to discharge planners and partners on the person–centered planning process and long term services and supports available.

Increase in number of rides utilized under the transportation program.

GOAL 3: ENHANCE QUALITY OF SERVICES

South Dakota's SUA will expand and improve services, collaborate with partners, provide training, define key measures, and utilize data to become more efficient and consistent. Only through continuous improvement can we meet the needs of the future.

OBJECTIVE 3.1

Review, update and educate all LTSS staff on policies and procedures to enhance aging services.

STRATEGIES

The Policy Workgroup and the LTSS Internal Workgroup will collaborate to identify procedural inconsistencies and potential policy updates seeking statewide consistency among staff.

Provide policy education and updates in-person, via technology or in a written format to all LTSS staff.

OBJECTIVE 3.2

Expand and enhance evidence-based preventive health promotion efforts through Title III-D funding.

STRATEGIES

Continue to support Chronic Disease Self-Management Programs (CDSMP) and Diabetes Self-Management Programs (DSMP) through Better Choices, Better Health®.

Provide outreach and technical assistance to expand and promote Better Choices, Better Health®.

OBJECTIVE 3.3

Enhance collaboration with entities responsible for various components of long-term care services.

STRATEGIES

Enhance collaboration with South Dakota's Department of Social Services, Medicaid Fraud Control Unit, Department of Health and various statewide associations.

Engage entities in cross-training and information exchanges to ensure consumer needs are met by Long-Term Care Ombudsmen, providers, regulators, and protective services.

Engage with entities and meet with them throughout the year to discuss scope, limitations, and systems improvement.

Collaborate via the LTSS Enhancement Workgroup to implement and coordinate diversion efforts to minimize new Long Term Care resident admissions and transition current residents to home and community.

OBJECTIVE 3.4

Enhance senior legal service delivery systems.

STRATEGIES

Conduct outreach and educate the public about available legal services.

Educate individuals and consumers on programs available with the South Dakota Bar Association.

Continue to collaborate with the two contracted legal services programs in the state to enhance service delivery.

OBJECTIVE 3.5

Expand and enhance caregiver support efforts through the Administration on Aging's Title III E Family Caregiver Program.

STRATEGIES

Explore development of statewide supports and services for caregivers.

Support education and training targeted toward volunteer and family caregivers.

Provide outreach and technical assistance to expand and promote caregiver services.

Collaborate with partners to educate LTSS staff and caregivers on Alzheimer's disease and related disorders.

OBJECTIVE 3.6

Develop and implement a continuous quality improvement strategy within the Division of Long Term Services and Supports.

STRATEGIES

Define key measures, quality targets and minimum standards of compliance.

Conduct reviews with LTSS Regional Managers, Supervisors and Program Specialists to ensure alignment with the direction of the division.

Provide training to LTSS staff aligned to continuous quality improvement efforts in-person, via technology or in a written format.

In collaboration with the ADRC, implement consumer surveys for key programs and services.

OBJECTIVE 3.7

Improve data collection and integrity to better measure activity, performance, and quality.

STRATEGIES

Develop definitions, key data elements, processes for collection and submission of data and information; establish measures for all programs and funding sources to provide clear, comparable and accurate assessments of progress.

Update and maintain the LTSS Policy Manual.

Develop and deliver training, educational materials, and technical assistance to all LTSS staff.

OBJECTIVE 3.8

Protect the rights of residents living in nursing homes and assisted living centers, registered residential facilities and adult foster care.

STRATEGIES

Educate and empower residents regarding the LTC Ombudsman program, resident rights and provider responsibilities.

Collaborate with residents during resident council meetings to promote the rights of all residents in the facility.

Provide Ombudsman, residents rights, and other educational materials to residents, families, and staff in facilities.

GOAL 3: PERFORMANCE MEASURES

Increase number of policy trainings by LTSS Supervisors to the LTSS Specialists they manage.

Increase in the number of case audits to ensure quality and consistency among all LTSS staff.

Increase number of LTSS staff trained on referral process and programs available through Better Choices, Better Health®.

Increase number of units authorized for respite care services.

Increase number of LTSS staff trained on referral process and programs available through the CAREgiver Program.

Increase in number of consumers reporting satisfaction with LTSS services on the Quality of Life Survey.

Increase number of trainings provided to long term care residents and facility staff.

GOAL 4: EMPOWER THE WORKFORCE AND LOCAL COMMUNITY SUPPORTS

In recognizing the challenges that exist while providing aging services, the SUA must empower the workforce and community supports to ensure South Dakota's aging population has the ability to age in place with the quality of life they deserve.

OBJECTIVE 4.1

Foster career development and support for the workforce that serves older adults.

STRATEGIES

Improve recruitment, orientation, training and recognition efforts to encourage LTSS staff retention.

Facilitate internship opportunities for college students as a path to a career in aging services.

Collaborate with the South Dakota Department of Labor to form prospective partnerships with senior employment programs.

Collaborate with the Department of Health's Health Occupations for Today and Tomorrow (HOTT) program to form prospective partnerships.

Take an active part in exploring and identifying barriers to entering the direct care workforce.

OBJECTIVE 4.2

Support the success of local senior centers and the quality of services they provide.

STRATEGIES

Encourage LTSS staff engagement with senior centers and expansion of services and activities.

Hold forums for senior centers to share best practices.

Offer to have LTSS staff present during local senior center functions.

LTSS staff will provide local senior center information to consumers.

GOAL 4: PERFORMANCE MEASURES

Percent increase of LTSS staff retention.

Number of outreach events held at local senior centers.

Assuring Quality

All data aggregation and analysis is completed by LTSS staff who begin the process of trend identification as aggregation and analysis is being conducted. Data and trends are then presented to a quality management workgroup, consisting of staff members of DHS at different levels. The workgroup meets to discuss identified trends and related issues to set priorities for system-wide quality improvement. As a result of an analysis of the discovery and remediation information presented, system improvements are identified and design changes are made. The backbone of support for effective compilation of data for continuous quality improvement across LTSS consists of internal databases and their associated subsystems, and effective and objective reviews of case management and documentation as completed by designated staff within LTSS. Comparative data gleaned from these databases and case reviews are evaluated by the program staff and quality management workgroup to determine if system changes are warranted. Review of these reports may also lead to initiation of new improvement projects to benefit applicable individuals. The quality management work group prioritizes quality improvement activities and projects from those opportunities that provide the most benefit to the consumer, the community, providers, the organization and funding entities at the same time maximizing use of quality improvement resources.

Consideration is given to the issues based on the following criteria:
Regulatory requirements – required by law or funding source;
High risk – likelihood of adverse effects or outcomes;
High volume – affects many individuals;
High cost – causes a financial drain on the system;
High impact – potential to make significant change;
High likelihood of success – easy to implement and provides a successful outcome;
Problem prone – causes major problems if it occurs;
Feasibility of time and resources – cost and staff commitment required;
Measurability – data and resources can capture necessary information; and
Readiness to address issue – the time, situation, and climate are right.

After the quality management workgroup has identified a need for system improvement and decided action is needed, the design and development of the processes for implementing the system improvement is accomplished in coordination with other entities impacted.

Implementation of system improvement activities will be managed by the LTSS staff. Remediation, guidance and training to applicable individuals will be provided in person, through policy and manual edits, or via web conference as needed.

State Plan Guidance
Attachment A

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES
Older Americans Act, As Amended in 2016

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2016.

ASSURANCES

Sec. 305, ORGANIZATION

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title--
(2)The State agency shall-- except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

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

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

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

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

(c) An area agency on aging designated under subsection (a) shall be--…

(5) in the case of a State specified in subsection (b) (5), the State agency; and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the

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

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

Sec. 306(a), AREA PLANS

(a) Each area agency on aging…Each such plan shall--
(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-
(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

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

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

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

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared,
(I) identify the number of low-income minority older individuals in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—
(i) identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and
(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

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

(9) assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title;

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

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13) provide assurances that the area agency on aging will—
(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency--
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship;

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

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

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

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

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

to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

Each such plans shall comply with all of the following requirements:…

(3) The plan shall…
(B) with respect to services for older individuals residing in rural areas—
(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000…

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

(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act…

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

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

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

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project

grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

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

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

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals --
(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent abuse of older individuals;
(ii) receipt of reports of abuse of older individuals;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;…

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

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

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

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

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

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

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

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

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

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

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

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

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

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

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(a) ELIGIBILITY.—In order to be eligible to receive an allotment under this subtitle, a State shall include in the state plan submitted under section 307--
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

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

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

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

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

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order…

State Plan Guidance
Attachment A (Continued)

REQUIRED ACTIVITIES

Sec. 305 ORGANIZATION
(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—. . .
(2) the State agency shall—
(G)(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas; . . .
(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals; and
(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

Sec. 306 – AREA PLANS

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

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

Sec. 307(a) STATE PLANS

(1) The plan shall—

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

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

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

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

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). **Note:** "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.

(5) The plan shall provide that the State agency will:
(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) afford an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

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

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

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

_____ _____
Signature and Title of Authorized Official *Date*

State Plan Guidance
Attachment B

INFORMATION REQUIREMENTS

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

Section 305(a)(2)(E)
Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

The Division of Long Term Services and Supports works 23 fully staffed and 3 itinerant local field offices, 5 Aging and Disability Resource Connections (ADRC) Call Centers, 5 Medical Review Team Nurses and 6 Local Long Term Care Ombudsmen which strategically provide statewide coverage. Having 26 local office dispersed throughout the State helps to ensure that preference will be given in providing services to older individuals with the greatest economic and social need and older individuals residing in rural areas. South Dakota has only two standard Metropolitan communities (Sioux Falls and Rapid City), the remainder of the state is considered either rural or frontier. Since a majority of our state is considered rural or frontier, the distribution of 26 local LTSS offices, ensures preference is being given in providing services to older individuals residing in rural areas. LTSS has offices on or adjacent to the following Native American Tribal Areas; Bear Butte, Crow Creek, Cheyenne River, Flandreau, Lower Brule, Pine Ridge, Rosebud, Standing Rock, Sisseton Wahpeton, and Yankton. The counties which make up some of these tribal areas are among some of the poorest counties in the nation, the accessibility of LTSS offices adjacent to these areas ensures preference is being given in providing services to low-income minority older individuals. There are significant populations of refugees living in cities and towns throughout the state, the Division enjoys a good working relationship with the following entities to ensure a preference is being given to older individuals with limited English proficiency or individuals with Sensory Impairments: Lutheran Social Services, which provides interpreter services, Interpre Talk, Website Interpreter Services, Local High Schools, English as a Second Language programs, Local College and Universities, Tribal Agency staff members, Multi-Cultural Centers, A to Z World Languages, Department of Social Services, Communications for the Deaf, Relay South Dakota, Division of Services to the Blind and Visually Impaired, and ISI for Sign Language.

Screening methodologies are employed to ascertain that the individuals receiving preference for assistance are either elderly or adults with disabilities and in most need. Service is provided in all counties, including all tribal lands. Oglala Lakota County is entirely within the Pine Ridge Indian Reservation and contains part of Badlands National Park. The Oglala Lakota County's median household income makes it the forty-eighth poorest county in the United States. According to the

US 2010 Census Bureau, 2007 – 2011, Oglala Lakota County is home to a population of which 53.5% are below poverty level.

LTSS supplements Title VI tribal nutrition programs on four of South Dakota's reservations. In addition, the South Dakota Title III nutrition program operates meal sites at additional sites on or in close proximity to tribal lands.

Tribal Nutrition Site	2013 Title III C Contracted Meals	2014 Title III C Contracted Meals	2014 Title VI Meals	2015 Title III C Contracted Meals	2015 Title VI Meals	2016 Title III C Contracted Meals
Cheyenne River	5720	5720	10,738	5720	13,817	5720
Rosebud	29333	29333	42,018	29333	44,798	29333
Sisseton - Wahpeton	4180	4180	42,535	4180	47,366	4180
Standing Rock	4180	4180	145,103	4180	94,642	4180

Section 306(a)(17)

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

The Office of Emergency Management is charged with the overall mission of protecting South Dakota's citizens and their property from the effects of natural, manmade, and technological disasters. To fulfill this mission, the office recognizes and utilizes the four phases of emergency management: Preparedness; Response; Recovery; and Mitigation. The South Dakota State Emergency Operations Plan is a product of the Office of Emergency Management with the main purpose of assisting state government agencies in responding to an emergency or disaster when it exceeds the local government's capability to respond. Emergency or disaster conditions may require state agency personnel to perform their normal duties under unusual circumstances and normal functions that do not contribute to the emergency operations may be suspended or redirected for the duration of the emergency. The South Dakota State Emergency Operations Plan establishes policy for state government agencies in their response to the threat of natural, technological, or national security emergency/disaster situations. It documents the policies, concept of operations, organizational structures and specific responsibilities of state agencies in their response to provide for the safety and welfare of its citizens and addresses the need for preparedness, response, recover, and mitigation activities to enhance the State's overall capability to cope with potential hazards. It is the responsibility of each state agency to respond in a manner consistent with its capabilities as identified and agreed to in the South Dakota State Emergency Operations Plan. The South Dakota Department of Human Services' Continuity of Operations Plan (COOP) establishes policy and guidance to ensure the execution of the mission-essential functions for the Department in the event that an emergency threatens or incapacitates

operations. Specifically, the plan is designed to: ensure that the Department is prepared to respond to emergencies, recover from them, and mitigate against their impacts; ensure that the Department is prepared to provide critical services in an environment that is threatened, diminished, or incapacitated; provide timely direction, control, and coordination to department leadership and other critical customers before, during, and after an event or upon notification of a credible threat; establish and enact time-phased implementation procedures to activate various components of the plan; facilitate the return to normal operating conditions as soon as practical, based on circumstances and the threat environment; ensure that the plan is viable and operational, and is compliant with all guidance documents; ensure that the plan is fully capable of addressing all types of emergencies, or "all hazards" and that mission-essential functions are able to continue with minimal or no disruption during all types of emergencies.

The Office of Emergency Management maintains a Duty Officer Program which provides assistance to county emergency managers with the location and acquisition of resources and provides state agencies with information regarding current events as they relate to the agency mission requirements. The Duty Officer is on call 24 hours a day, seven days a week. The Duty Officer can be contacted by county emergency managers or by assigned state agency representatives whenever there is a need for state resources or assistance, including the National Guard. The Department maintains a "wallet card" to be carried by Department leadership which provides up to date contact information for all leadership positions within the Department. When contacted by the Office of Emergency Management Duty Officer, the Secretary of the Department will contact Division leaders to engage and inform staff members of their respective Division regarding the need for emergency operations.

The Office of Emergency Management also makes available brochures for public education on severe weather/storms, winter weather preparedness, family communications planning and the SD Be Ready program, which provides checklists and preparation guides to prepare individuals for a range of disaster or emergency conditions. Natural disasters, epidemics or major emergencies may require a person to isolate themselves and their family from others for a period of time. This program provides information on being informed, being ready and staying safe.

Examples of the system at work are:

•When flood conditions are identified in a South Dakota community, an emergency operations plan is activated and pre-selected staff members from several different state agencies travel to the affected community to offer support and services directly in a door-to-door campaign.

•When flood conditions are identified in a neighboring state, an emergency operations plan is activated and pre-selected staff members from several different state agencies coordinate assistance with relocation of affected residents.

•When severe cold weather is projected, a call is made from the Duty Officer to the Secretary of the Department of Human Services. Within a short period of time, a message is transmitted to all field offices of Long Term Services and Supports and to the Elderly Nutrition Projects warning of the severe cold forecast and to check with individuals at risk and assure an adequate supply of emergency "heater" meals are on hand.

Section 307(a)(2)
The plan shall provide that the State agency will --…
(C*) specify a minimum proportion* of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). *(Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)*

South Dakota does not utilize Area Agencies on Aging.

Section 307(a)(3)

The plan shall--
...
(B) with respect to services for older individuals residing in rural areas--

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

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

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

The following table illustrates the amount of Title III funds expended on the specified categories (Transportation – access to services, Case management – In home services, and Legal assistance) over the last three federal fiscal years.

Title III Funds	FFY 2013	FFY 2014	FFY 2015	FFY 2016
Transportation	$ 341,966	$ 343,096	$ 338,484	$ 336,912
Case Management	$ 1,665,245	$ 1,525,136	$ 1,426,068	$ 1,323,002
Legal Assistance	$ 110,793	$ 102,982	$ 119,748	$ 114,223

Actual spending:

Services	2000 Base Federal Only	FY 2013 Federal Only	FY 2014 Federal Only	FY 2015 Federal Only	FY 2016 Federal Only
Transportation	$ 297,958	$ 341,966	$ 343,096	$ 338,484	$ 336,912
Case Mgmt	$ 901,060	$ 1,665,245	$ 1,525,136	$ 1,426,068	$ 1,323,002
Legal Assistance	$ 84,203	$ 110,793	$ 102,982	$ 119,748	$ 114,223

The above mentioned program spending is 20%, 53% and 66% respectively above the base spending. The State agency has methodologies in place to assure the spending will remain at or above the expended funding for the services listed for fiscal year 2000.

South Dakota's projected spending for FY2017 – FY 2021

Services	FY2017	FY2018	FY2019	FY2020	FY2021
Transportation	$ 337,475	$ 337,475	$ 337,475	$ 337,475	$ 337,475
Case Mgmt	$ 1,309,772	$ 1,296,674	$ 1,283,707	$ 1,270,870	$ 1,258,161
Legal Assistance	$ 115,365	$ 116,519	$ 117,684	$ 118,861	$ 120,050

South Dakota has only two standard Metropolitan communities (Sioux Falls and Rapid City), the remainder of the state is considered either rural or frontier.

In FY2016, the State met the needs by utilization of contracts with transportation and legal service providers and by the existence of 26 local Adult Services and Aging (ASA) offices dispersed throughout the State. Every county in the State is covered by one of the 26 local ASA offices.

Section 307(a)(10)

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

Since a majority of our state is considered rural or frontier and there are the distribution of 26 local LTSS offices, ensures preference is being given in providing services to older individuals residing in rural areas.
See above: Section 305(a)(2)(E) and Section 307(a)(3)

Section 307(a)(14)

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

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

The total number of minority aged 60 and over (not considering limited English) is 9,714. The total number of minority aged 60 and over with limited English proficiency is 913. The total number of minority aged 60 and over with limited English proficiency and fall below the poverty line in South Dakota is estimated at 247. The poverty rate among elderly minorities with limited English proficiency is estimated at 27%, which is a much higher poverty rate compared to the state average of 14%.

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

See above: Section 305(a)(2)(E) and Section 307(a)(3). LTSS has offices on or adjacent to the following Native American Tribal Areas; Bear Butte, Crow Creek, Cheyenne River, Flandreau, Lower Brule, Pine Ridge, Rosebud, Standing Rock, Sisseton Wahpeton, and Yankton. The counties which make up some of these tribal areas are among some of the poorest counties in the nation, the accessibility of LTSS offices adjacent to these areas ensures preference is being given in providing services to low-income minority older individuals. There are significant populations of refugees living in cities and towns throughout the state. The Division works with entities such as Lutheran Social Services, which provides interpreter services, Interpre-Talk, local English as a Second Language programs, Multi-Cultural centers and others to ensure services are being provided to those individuals with limited English proficiency. Additionally, the Division of LTSS plans to satisfy the services needs of the low income minority older individuals by: collaborating with organizations representing diverse communities to promote long tem services and supports; Providing outreach to rural, ethnic, culturally diverse and low income communities to increase awareness; Expand the areas of service by creating or expanding to reach these individuals; Continue and improve collaboration and outreach to the Native American Tribal areas. In an effort to satisfy the service needs of low income older individuals with limited English proficiency Department has taken steps to ensure access by diversifying the website access with various language options and including various language options with brochures that are distributed.

Section 307(a)(21)

The plan shall --

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

Please see the above section 305(a)(2)(E). LTSS has offices on or adjacent to the following Native American Tribal Areas; Bear Butte, Crow Creek, Cheyenne River, Flandreau, Lower Brule, Pine Ridge, Rosebud, Standing Rock, Sisseton Wahpeton, and Yankton. The counties which make up some of these tribal areas are among some of the poorest counties in the nation, the accessibility of LTSS offices adjacent to these areas ensures preference is being given in providing services to low-income minority older individuals. Additionally, the Division of LTSS plans to satisfy the services needs of the low income minority older individuals by: collaborating with organizations representing diverse communities to promote long tem services and supports; Providing outreach to rural, ethnic, culturally diverse and low income communities to increase awareness; Expand the areas of service by creating or expanding to reach these individuals; Continue and improve collaboration and outreach to the Native American Tribal areas.

Section 307(a)(28)

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

(B) Such assessment may include—

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

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

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

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

An analysis by Abt and Associates in 2015, resulted in revised projections regarding the growth rate of the elderly and elderly with disabilities populations in South Dakota. The current projections are that the number of elders (>65) will increase aby approximately 84% in the year 2035 relative to decennial Census totals in the year 2010, increasing to approximately 103,000 to 2226,000. The number of elders with disabilities will peak in 2030, increasing by about 33,000 to 85,000 or 71% higher than the decennial Census year 2010 total. By 2035, this number will fall slightly as the relative proportion of younger elderly individuals (65-74 years) increase in relation to the proportion of older elderly individuals (age 75+). Although growth rates for the elderly and elderly with disabilities populations have slowed relative to past projections, it remains the case that growth rates and associated demand for long term services and supports are not balanced across the state. Growth rates are projected to be higher West River than East River, and the regions including the two metropolitan areas of Sioux Falls and Rapid City continue to exhibit the fastest rates of anticipated growth as well as the largest growth in the overall number of elders. Nursing home capacity and utilization rates have continued to drop, both in South Dakota and nationwide. Although South Dakota's utilization rates remain higher than the national average, the drop in utilization between 2006 and 2011 indicates the gap is shrinking. South Dakota continues to have the 2nd fewest Medicare skilled home health episodes in the nation, with just over 5 episodes per 100 elderly individuals. Home and community based services are a critical component in allowing individuals to remain in the community. There has been no perceptible shift in availability of services, with services such as adult day, senior centers, nutrition programs, and homemaker services remaining at similar, relatively low levels. The Abt report concludes that:

"It is clear that recent policy changes in South Dakota as described in the introduction have successfully accelerated the decline in nursing home utilization, substantially reducing the gap relative to national utilization rates. Assisted living utilization has increased in parallel, but we do not observe concurrent increases in skilled Medicare home health or HCBS (home and community based services).

The results naturally lead to speculation on how the needs of individuals are being met in light of decreasing nursing home utilization without a correlating increase in the use of formal supports. Per the Department of Social Services, South Dakota ranked within the top five states nationwide in market penetration for private long term care insurance as of June 2013, potentially indicating on way in which residents are bridging the gap."

The state continues to face the challenge of rebalancing long term services and supports in South Dakota through increased awareness of community based alternatives, enhancing and improving available supports and improving support for family caregivers. The full Abt and Associates report is available in Attachment G.[6]

Section 307(a)(29)

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

The Office of Emergency Management is charged with the overall mission of protecting South Dakota's citizens and their property from the effects of natural, manmade, and technological disasters. To fulfill this mission, the office recognizes and utilizes the four phases of emergency management: Preparedness; Response; Recovery; and Mitigation. The South Dakota State Emergency Operations Plan is a product of the Office of Emergency Management with the main purpose of assisting state government agencies in responding to an emergency or disaster when it exceeds the local government's capability to respond. Emergency or disaster conditions may require state agency personnel to perform their normal duties under unusual circumstances and normal functions that do not contribute to the emergency operations may be suspended or redirected for the duration of the emergency. The South Dakota State Emergency Operations Plan establishes policy for state government agencies in their response to the threat of natural, technological, or national security emergency/disaster situations. It documents the policies, concept of operations, organizational structures and specific responsibilities of state agencies in their response to provide for the safety and welfare of its citizens and addresses the need for preparedness, response, recover, and mitigation activities to enhance the State's overall capability to cope with potential hazards. It is the responsibility of each state agency to respond in a manner consistent with its capabilities as identified and agreed to in the South Dakota State Emergency Operations Plan. The South Dakota Department of Human Services' Continuity of Operations Plan (COOP) establishes policy and guidance to ensure the execution of the mission-essential functions for the Department in the event that an emergency threatens or incapacitates operations. Specifically, the plan is designed to: ensure that the Department is prepared to respond to emergencies, recover from them, and mitigate against their impacts; ensure that the Department is prepared to provide critical services in an environment that is threatened, diminished, or incapacitated; provide timely direction, control, and coordination to department leadership and other critical customers before, during, and after an event or upon notification of a credible threat; establish and enact time-phased implementation procedures to activate various components of the plan; facilitate the return to normal operating conditions as soon as practical, based on circumstances and the threat environment; ensure that the plan is viable and operational, and is compliant with all guidance documents; ensure that the plan is fully capable of addressing all types of emergencies, or "all hazards" and that mission-essential functions are able to continue with minimal or no disruption during all types of emergencies.

[6] Abt Associates' analysis of South Dakota Data Center's Population Projections data, 2010 and American Community Survey (revised in 2015)

The Office of Emergency Management maintains a Duty Officer Program which provides assistance to county emergency managers with the location and acquisition of resources and provides state agencies with information regarding current events as they relate to the agency mission requirements. The Duty Officer is on call 24 hours a day, seven days a week. The Duty Officer can be contacted by county emergency managers or by assigned state agency representatives whenever there is a need for state resources or assistance, including the National Guard. The Department maintains a "wallet card" to be carried by Department leadership which provides up to date contact information for all leadership positions within the Department. When contacted by the Office of Emergency Management Duty Officer, the Secretary of the Department will contact Division leaders to engage and inform staff members of their respective Division regarding the need for emergency operations.

The Office of Emergency Management also makes available brochures for public education on severe weather/storms, winter weather preparedness, family communications planning and the SD Be Ready program, which provides checklists and preparation guides to prepare individuals for a range of disaster or emergency conditions. Natural disasters, epidemics or major emergencies may require a person to isolate themselves and their family from others for a period of time. This program provides information on being informed, being ready and staying safe.

Examples of the system at work are:
•When flood conditions are identified in a South Dakota community, an emergency operations plan is activated and pre-selected staff members from several different state agencies travel to the affected community to offer support and services directly in a door-to-door campaign.
•When flood conditions are identified in a neighboring state, an emergency operations plan is activated and pre-selected staff members from several different state agencies coordinate assistance with relocation of affected residents.
•When severe cold weather is projected, a call is made from the Duty Officer to the Secretary of the Department of Human Services. Within a short period of time, a message is transmitted to all field offices of Long Term Services and Supports and to the Elderly Nutrition Projects warning of the severe cold forecast and to check with individuals at risk and assure an adequate supply of emergency "heater" meals are on hand.

Section 307(a)(30)
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

The Office of Emergency Management is charged with the overall mission of protecting South Dakota's citizens and their property from the effects of natural, manmade, and technological disasters. To fulfill this mission, the office recognizes and utilizes the four phases of emergency management: Preparedness; Response; Recovery; and Mitigation. The South Dakota State Emergency Operations Plan is a product of the Office of Emergency Management with the main purpose of assisting state government agencies in responding to an emergency or disaster when it exceeds the local government's capability to respond. Emergency or disaster conditions may require state agency personnel to perform their normal duties under unusual circumstances and normal functions that do not contribute to the emergency operations may be suspended or

redirected for the duration of the emergency. The South Dakota State Emergency Operations Plan establishes policy for state government agencies in their response to the threat of natural, technological, or national security emergency/disaster situations. It documents the policies, concept of operations, organizational structures and specific responsibilities of state agencies in their response to provide for the safety and welfare of its citizens and addresses the need for preparedness, response, recover, and mitigation activities to enhance the State's overall capability to cope with potential hazards. It is the responsibility of each state agency to respond in a manner consistent with its capabilities as identified and agreed to in the South Dakota State Emergency Operations Plan. The South Dakota Department of Human Services' Continuity of Operations Plan (COOP) establishes policy and guidance to ensure the execution of the mission-essential functions for the Department in the event that an emergency threatens or incapacitates operations. Specifically, the plan is designed to: ensure that the Department is prepared to respond to emergencies, recover from them, and mitigate against their impacts; ensure that the Department is prepared to provide critical services in an environment that is threatened, diminished, or incapacitated; provide timely direction, control, and coordination to department leadership and other critical customers before, during, and after an event or upon notification of a credible threat; establish and enact time-phased implementation procedures to activate various components of the plan; facilitate the return to normal operating conditions as soon as practical, based on circumstances and the threat environment; ensure that the plan is viable and operational, and is compliant with all guidance documents; ensure that the plan is fully capable of addressing all types of emergencies, or "all hazards" and that mission-essential functions are able to continue with minimal or no disruption during all types of emergencies.

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The Office of Emergency Management also makes available brochures for public education on severe weather/storms, winter weather preparedness, family communications planning and the SD Be Ready program, which provides checklists and preparation guides to prepare individuals for a range of disaster or emergency conditions. Natural disasters, epidemics or major emergencies may require a person to isolate themselves and their family from others for a period of time. This program provides information on being informed, being ready and staying safe.

Examples of the system at work are:

•When flood conditions are identified in a South Dakota community, an emergency operations plan is activated and pre-selected staff members from several different state agencies travel to the affected community to offer support and services directly in a door-to-door campaign.

•When flood conditions are identified in a neighboring state, an emergency operations plan is activated and pre-selected staff members from several different state agencies coordinate assistance with relocation of affected residents.
•When severe cold weather is projected, a call is made from the Duty Officer to the Secretary of the Department of Human Services. Within a short period of time, a message is transmitted to all field offices of Long Term Services and Supports and to the Elderly Nutrition Projects warning of the severe cold forecast and to check with individuals at risk and assure an adequate supply of emergency "heater" meals are on hand.

Section 705(a) ELIGIBILITY --

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

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).
(Note: Paragraphs (1) of through (6) of this section are listed below)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307--
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;
(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;
(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;
(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;
(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);
(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for-
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

The State of South Dakota has established programs in accordance with the requirements of chapter 307 and 705. The Division of Long Term Services and Supports as the State Unit on Aging (SUA) has established policies and procedures to ensure interested parties are encouraged and allowed access to provide input on programs provided through the Division. Public hearings are publicized and comments are taken into consideration and incorporated. When conducting outreach events the State Plan on Aging is distributed along with information on how to make comments.

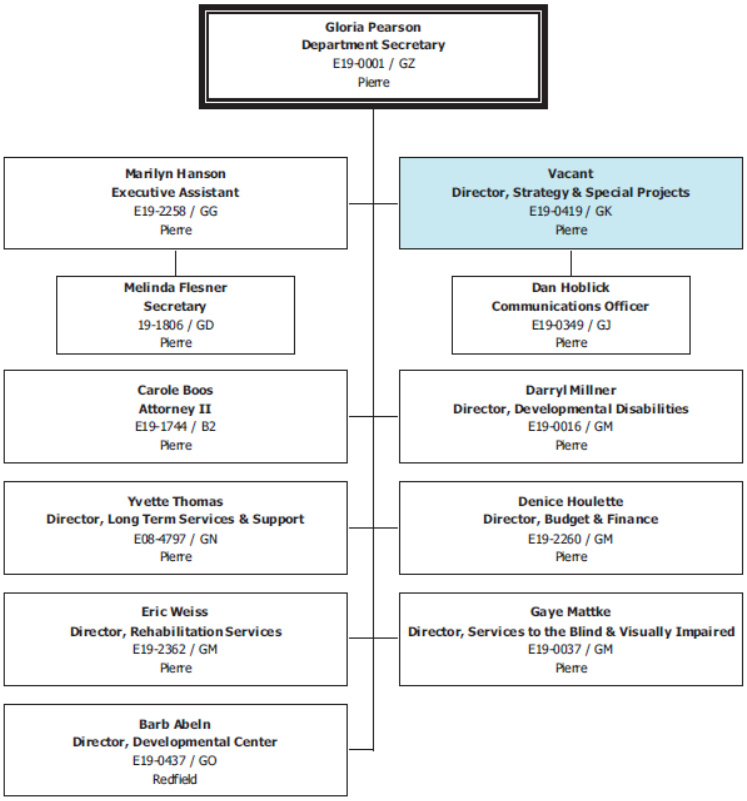
The State assures that it does not permit cost sharing for and from the following:
Information and assistance, outreach, benefits counseling, or case management services.
Ombudsman, elder abuse prevention, legal assistance, or other consumer protection services.
Congregate and home delivered meals.
Any services delivered through tribal organizations.
By a low-income older individual if the income of such individual is at or below the Federal poverty line.

The State of South Dakota does not consider any assets, savings, or other property owned by older individuals when defining low-income individuals who are exempt from cost sharing, when creating a sliding scale for the cost sharing, or when seeking contributions from any older individual.

The State Adult Protection program provides public education to help individuals identify and prevent elder abuse; receives reports of elder abuse; makes referrals to law enforcement, the Attorney General's office, South Dakota Advocacy, Veterans Administration, and the Social Security Administration as needed and appropriate. Policy is in place to ensure all information and records are kept confidential. The only time records are disclosed is upon receipt of a court order.

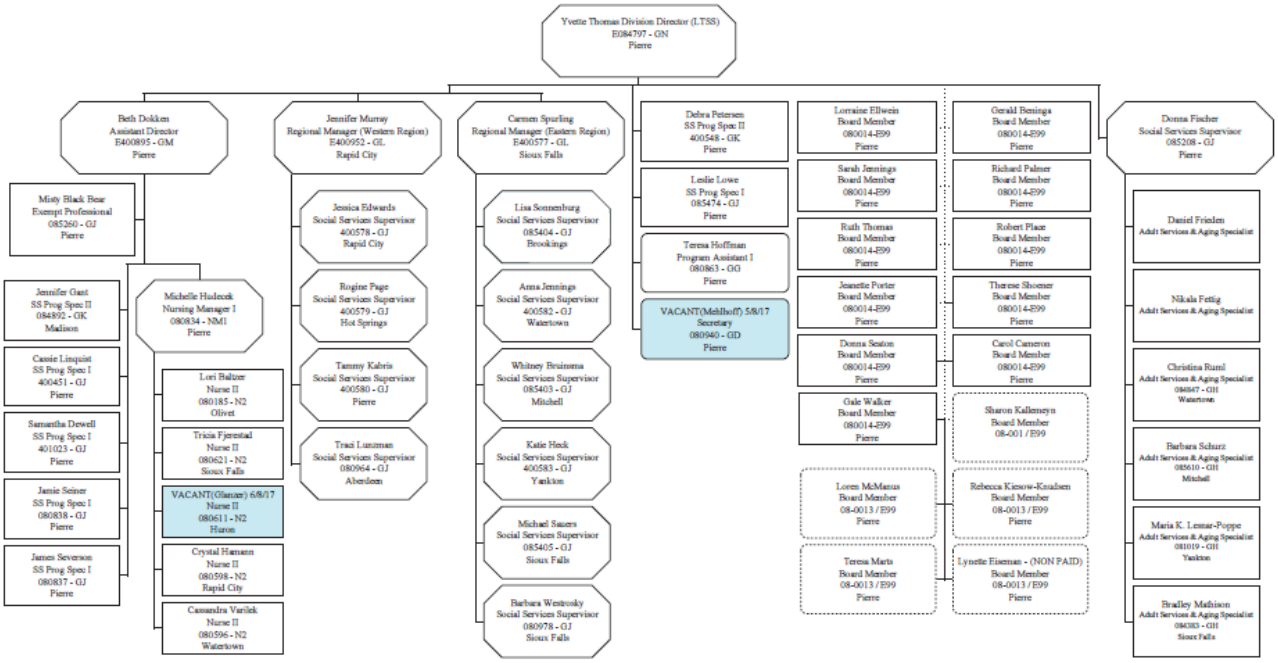
Attachment C

SOUTH DAKOTA DEPARTMENT OF HUMAN SERVICES
SECRETARIAT (1900)

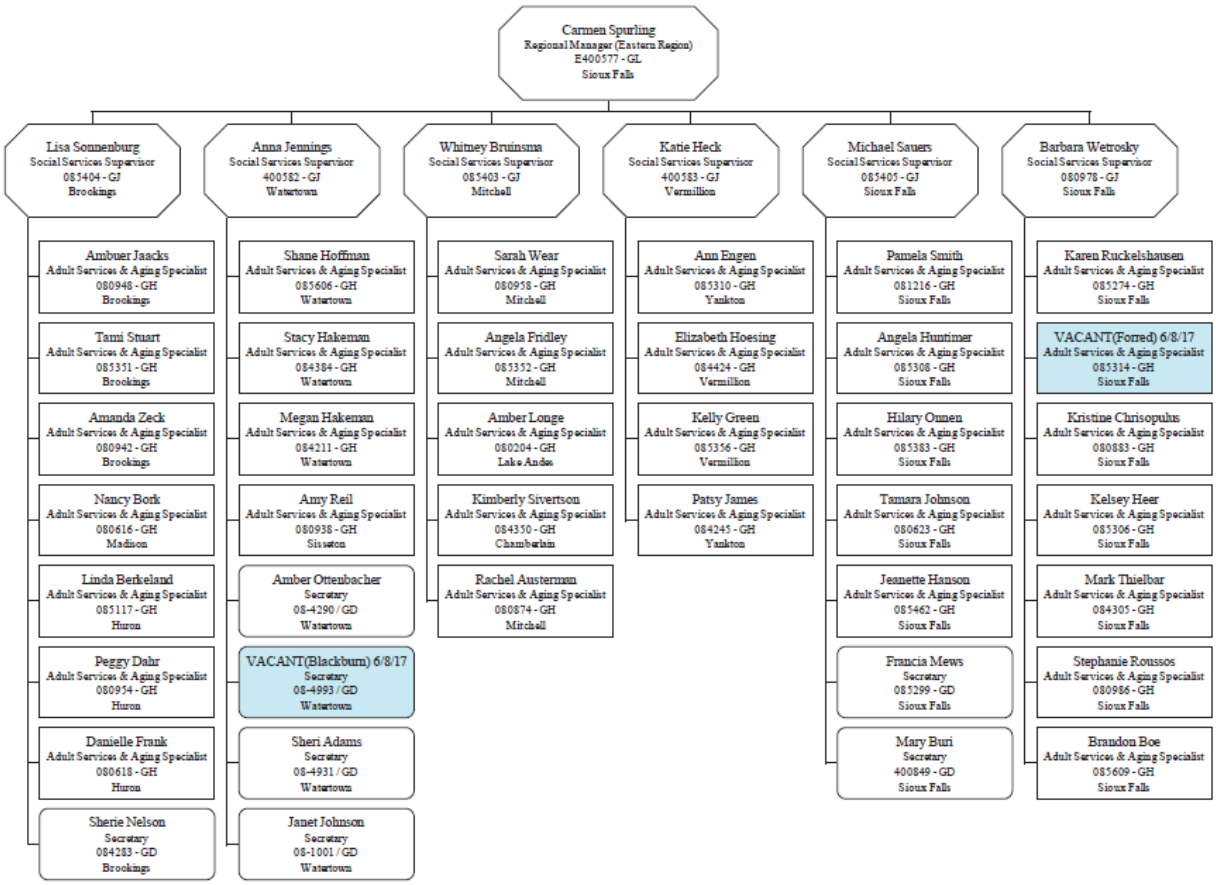


Attachment D

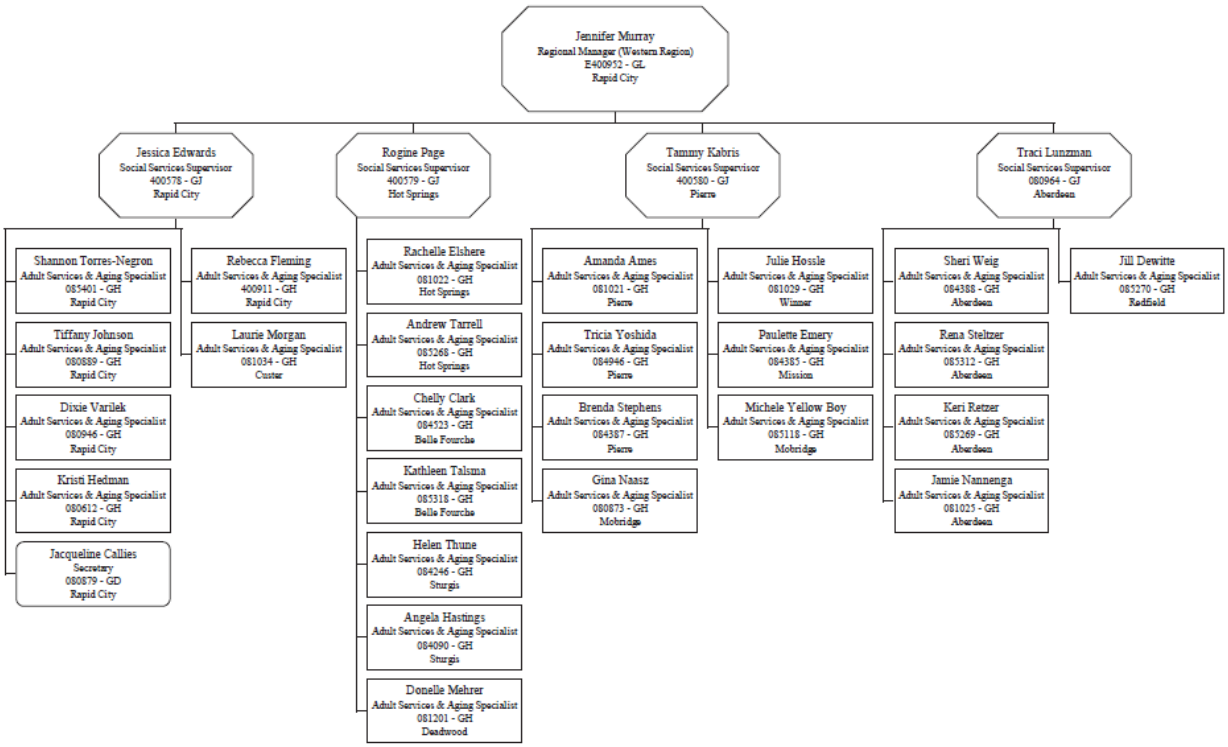
SOUTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DIVISION OF LONG TERM SERVICES & SUPPORT



SOUTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DIVISION OF LONG TERM SERVICES & SUPPORT - EASTERN REGION

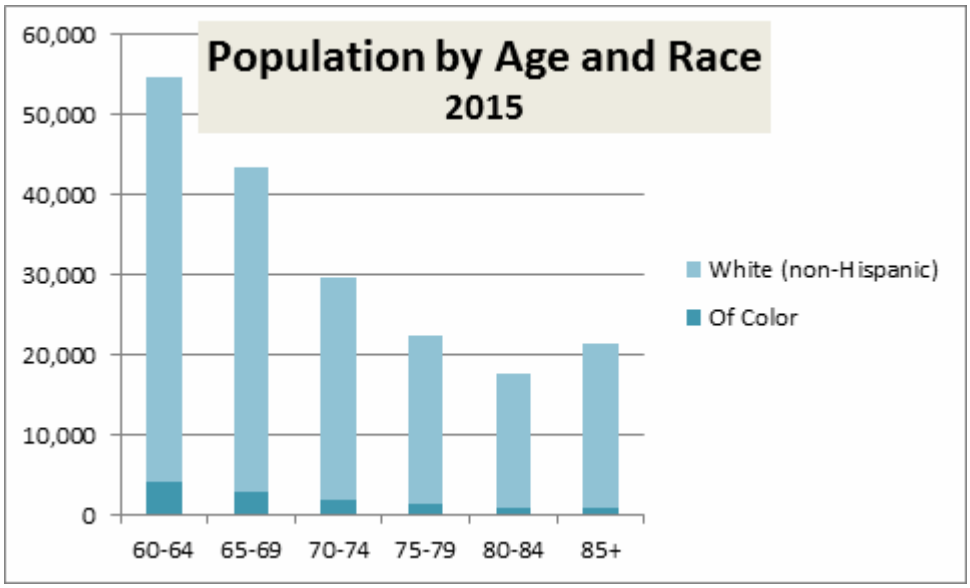


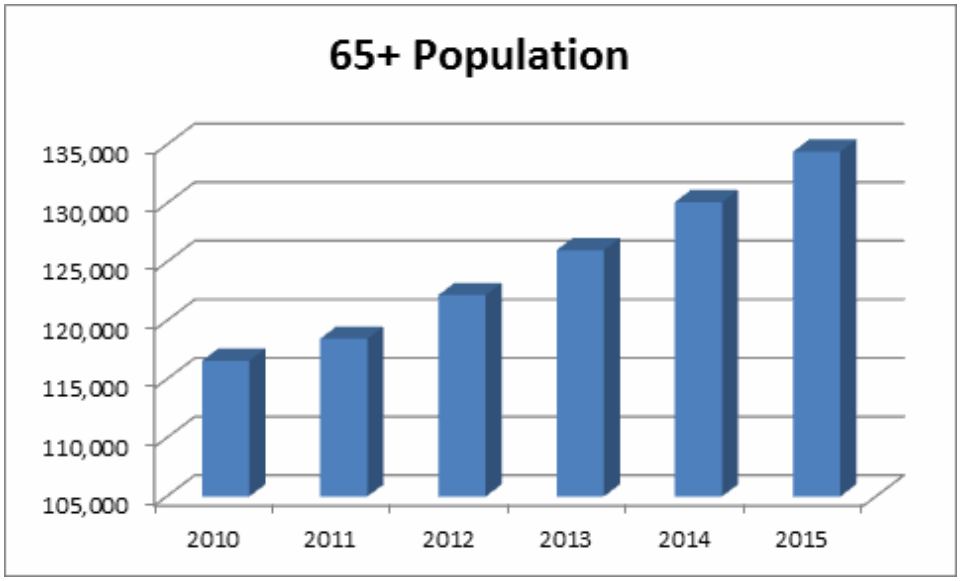
SOUTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DIVISION OF LONG TERM SERVICES & SUPPORT
WESTERN / CENTRAL REGION

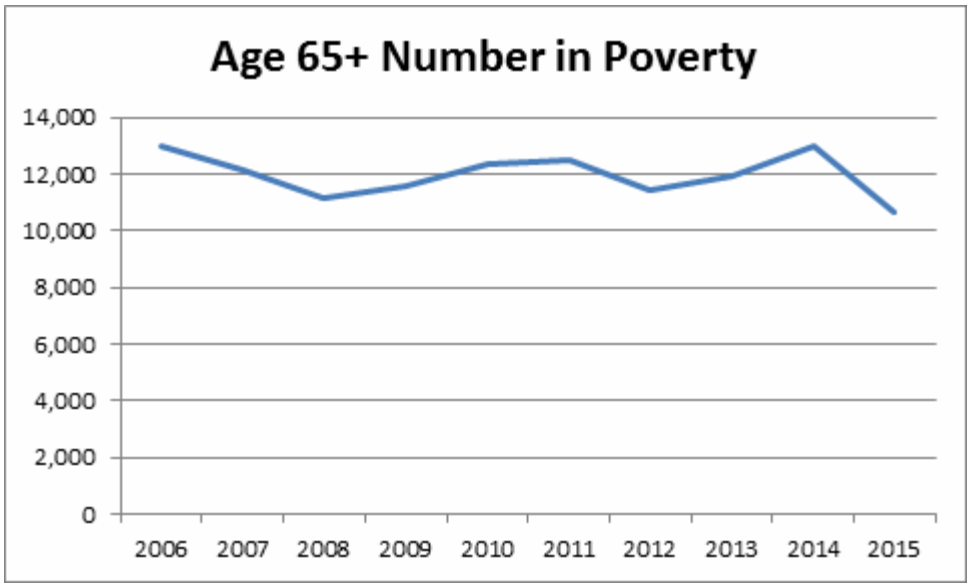


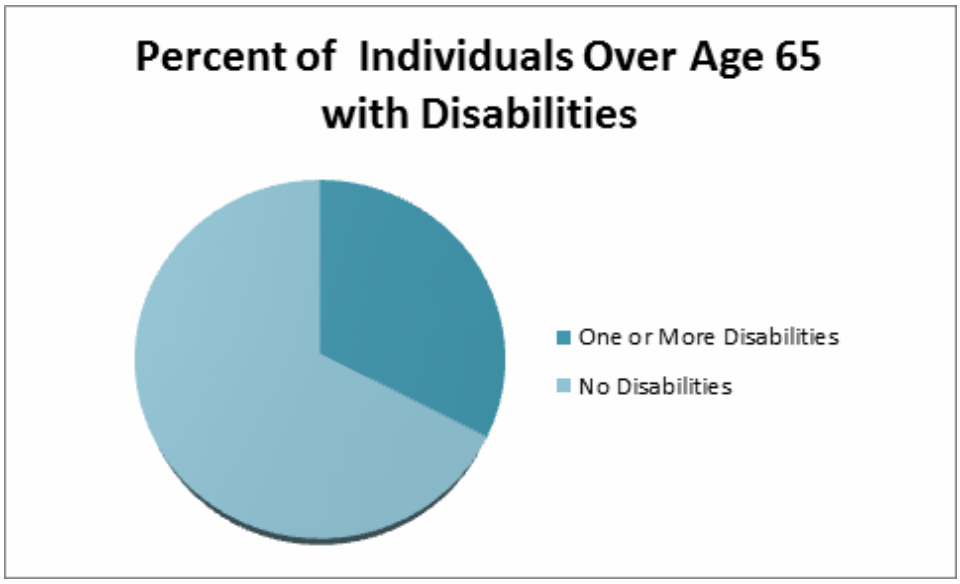
Attachment E

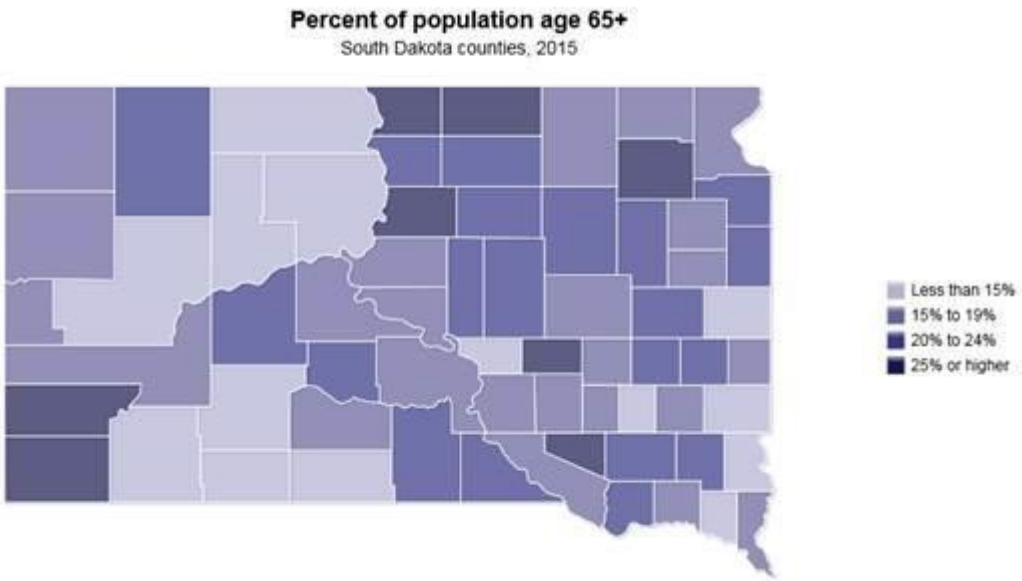
Statistical Charts and Graphs for South Dakota






Age 65+ Number in Poverty
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015


Percent of Individuals Over Age 65 with Disabilities
One or More Disabilities
No Disabilities



[7]

[7] U.S. Census Bureau, Decennial Census and Population Estimates. http://factfinder.census.gov

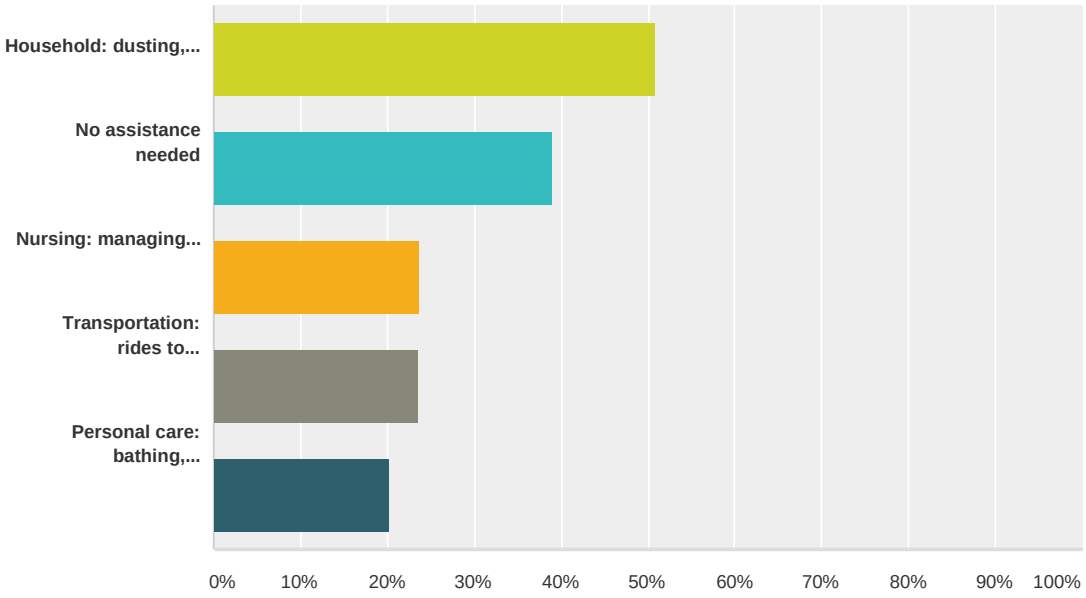
http://blackhillsknowledgenetwork.org

Attachment F

Consumer Survey

Q1 Currently, what kind of in-home assistance do you or a family member receive to complete daily living activities? Mark all that apply.

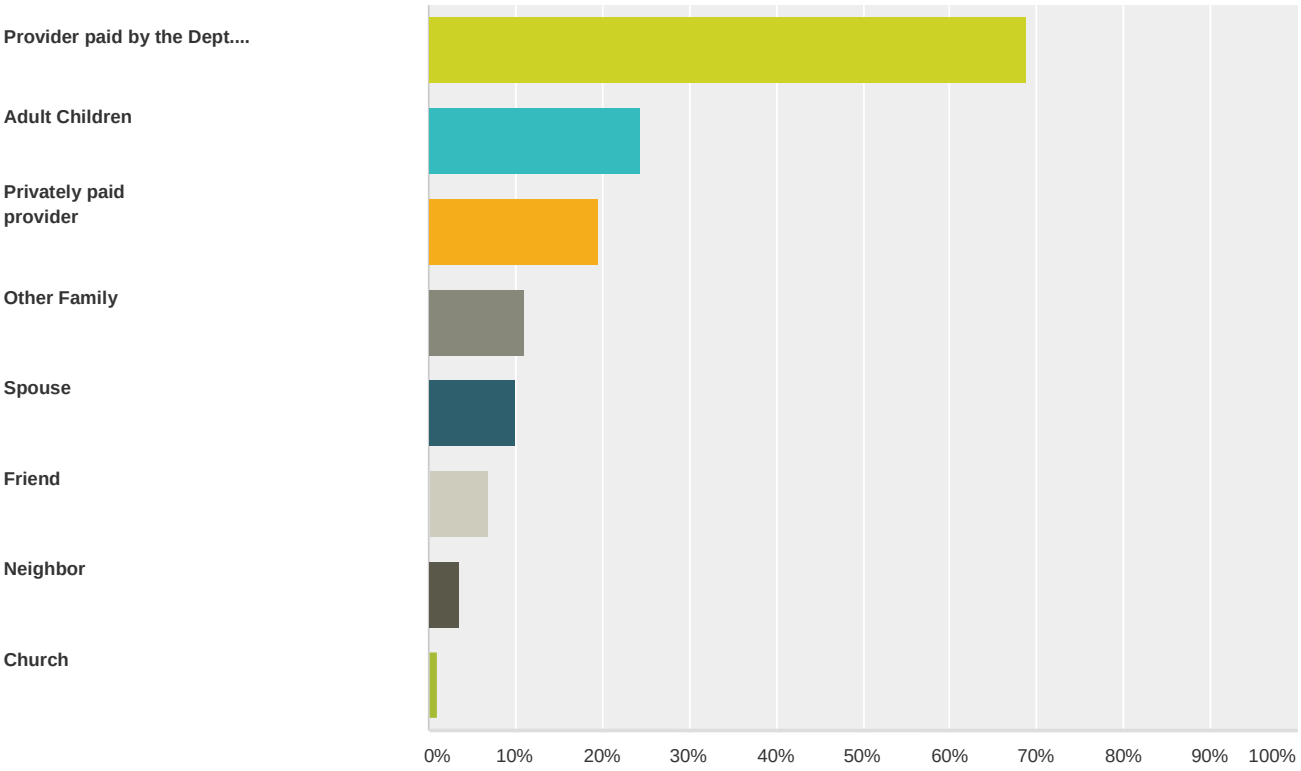
Answered: 1,256 Skipped: 0



Answer Choices	Responses	
Household: dusting, vacuuming, dishes, cooking, laundry, shopping	**50.96%**	640
No assistance needed	**39.09%**	491
Nursing: managing medication, skilled nursing	**23.81%**	299
Transportation: rides to appointments, community activities and events	**23.65%**	297
Personal care: bathing, dressing	**20.30%**	255
Total Respondents: 1,256		

Q2 Who provides the in-home assistance marked in Question #1.? Mark all that apply.

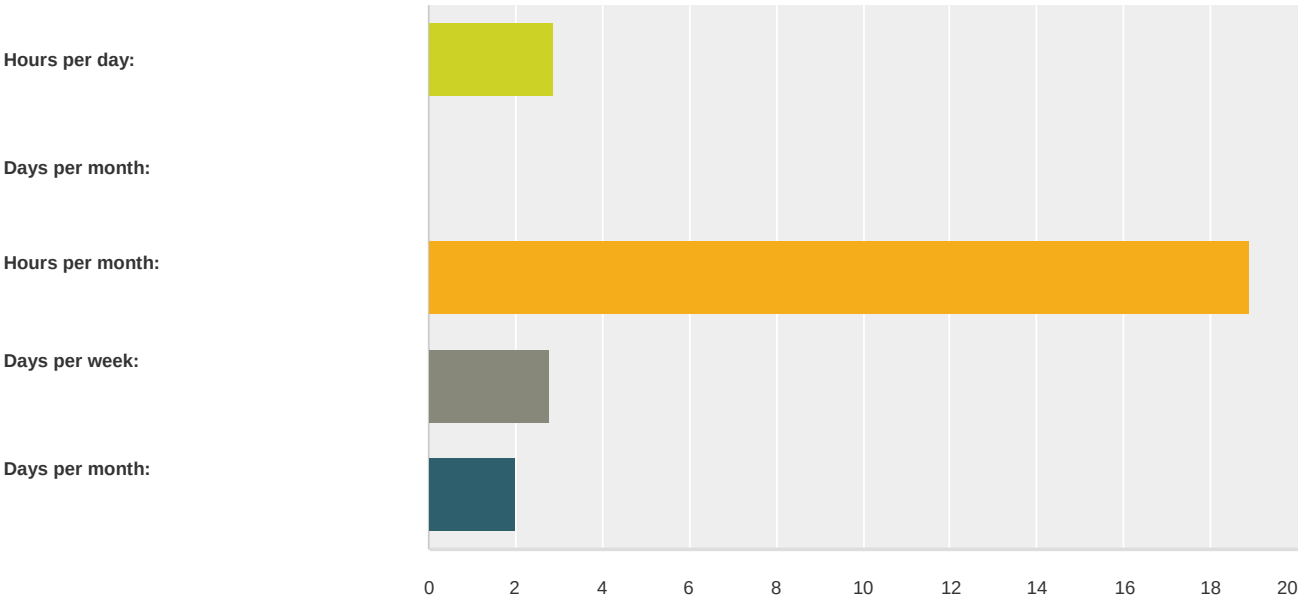
Answered: 722 Skipped: 534



Answer Choices	Responses	
Provider paid by the Dept. of Social Services	**68.98%**	498
Adult Children	**24.38%**	176
Privately paid provider	**19.53%**	141
Other Family	**11.08%**	80
Spouse	**10.11%**	73
Friend	**6.79%**	49
Neighbor	**3.60%**	26
Church	**1.11%**	8
Total Respondents: 722		

Q3 How much in-home assistance do you or a family member receive?

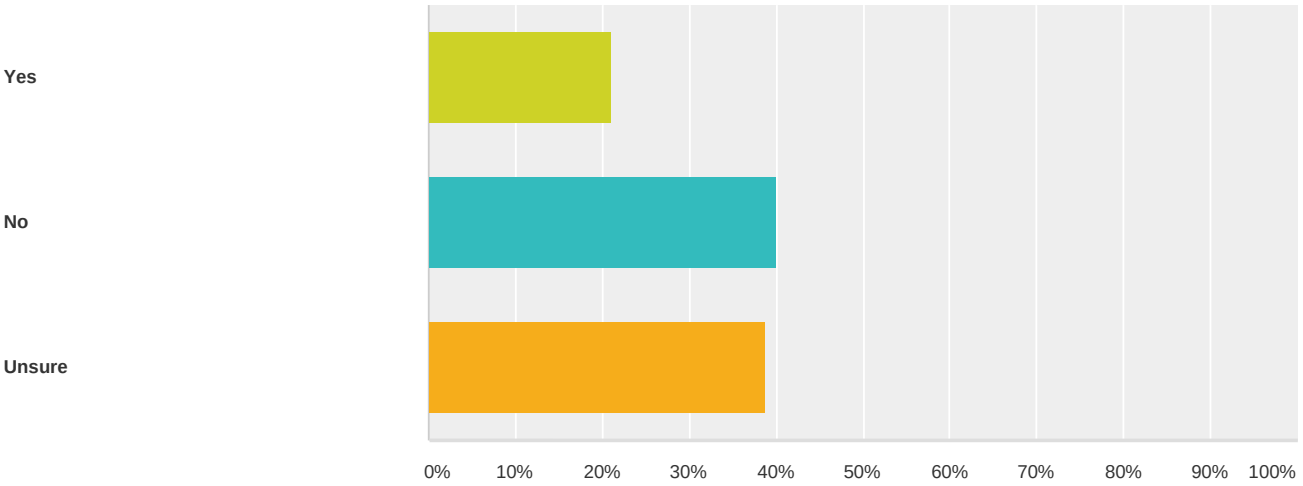
Answered: 722 Skipped: 534



Answer Choices	Average Number	Total Number	Responses
Hours per day:	3	2,063	711
Days per month:	0	0	0
Hours per month:	19	11,070	585
Days per week:	3	2,011	718
Days per month:	2	2	1
Total Respondents: 722			

Q4 If you were to no longer receive this type of in-home assistance, could you continue to stay in your home?

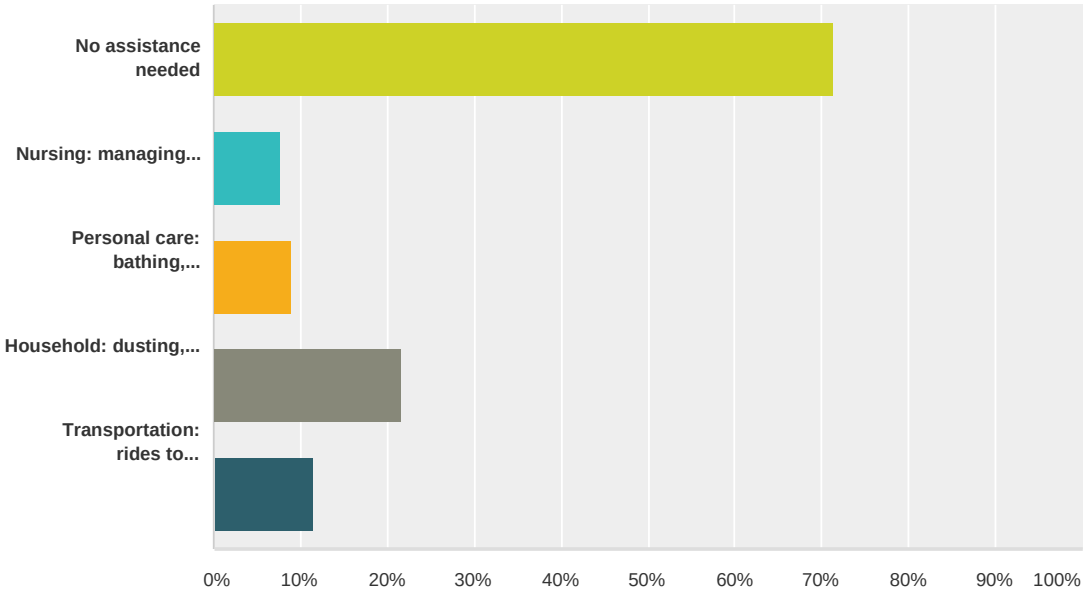
Answered: 722 Skipped: 534



Answer Choices	Responses	
Yes	**21.05%**	152
No	**40.17%**	290
Unsure	**38.78%**	280
Total		**722**

Q5 If you do not currently receive assistance, which of the following would help you to remain in your home? Mark all that apply.

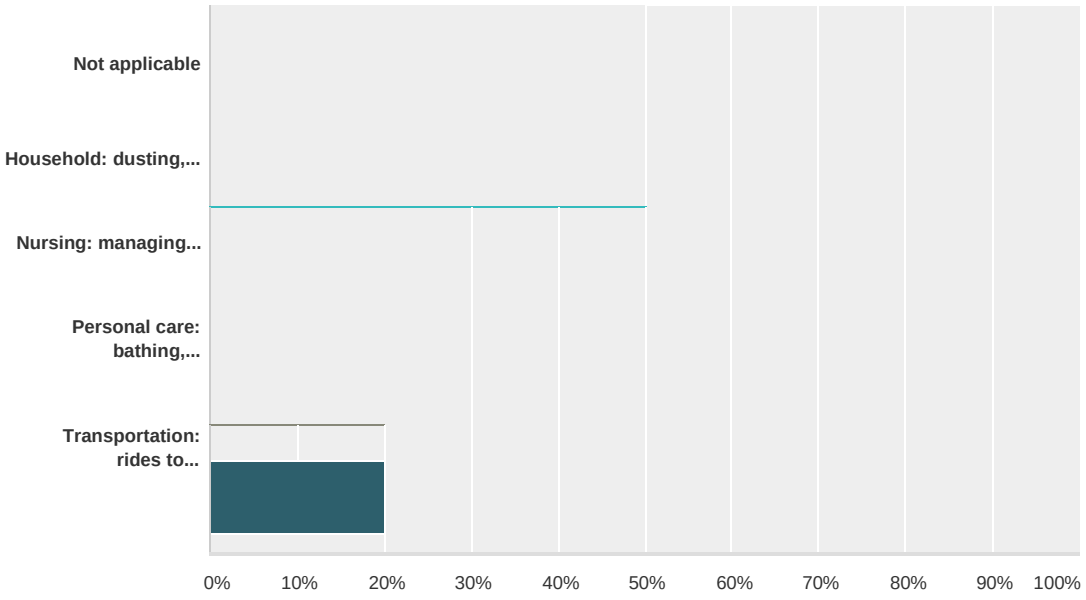
Answered: 484 Skipped: 772



Answer Choices	Responses	
No assistance needed	**71.49%**	346
Nursing: managing medication, skilled nursing	**7.64%**	37
Personal care: bathing, dressing	**8.88%**	43
Household: dusting, vacuuming, dishes, cooking, laundry, shopping	**21.69%**	105
Transportation: rides to appointments, community activities and events	**11.57%**	56
Total Respondents: 484		

Q6 If you received any of the following in- home services in the past, which services allowed you to remain in your home?

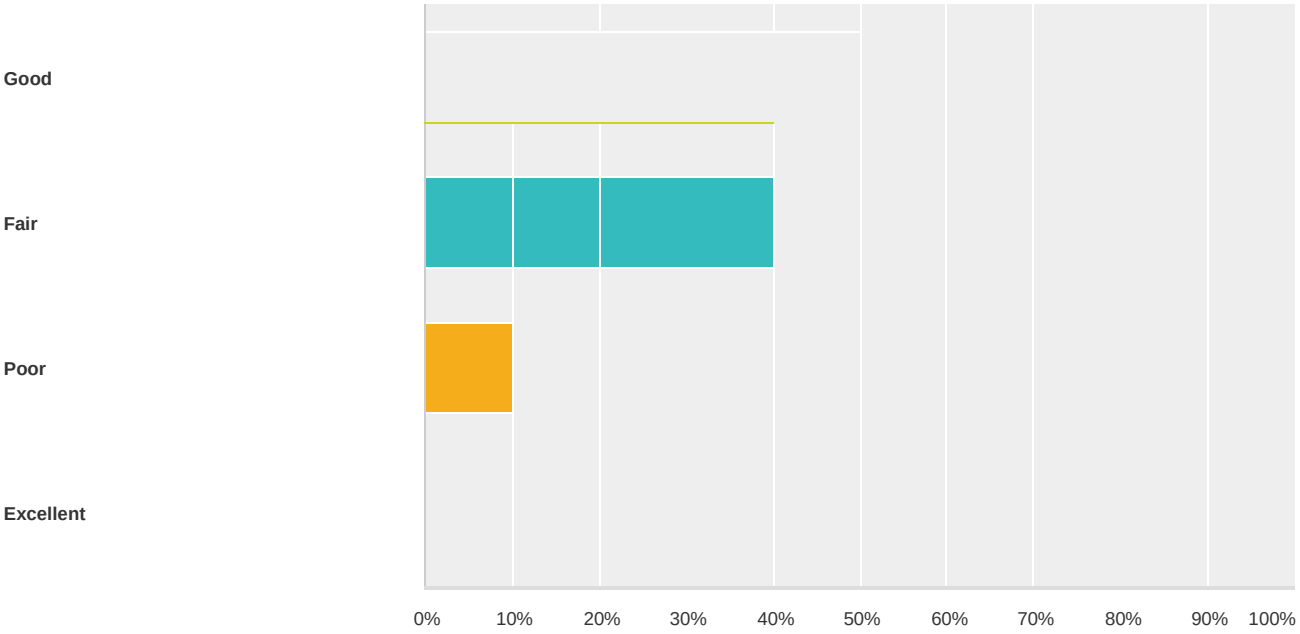
Answered: 1,190 Skipped: 66



Answer Choices	Responses	
Not applicable	**46.89%**	558
Household: dusting, vacuuming, dishes, cooking, laundry, shopping	**43.36%**	516
Nursing: managing medication, skilled nursing	**21.85%**	260
Personal care: bathing, dressing	**21.51%**	256
Transportation: rides to appointments, community activities and events	**20.17%**	240
Total Respondents: 1,190		

Q7 How would you rate your overall health:

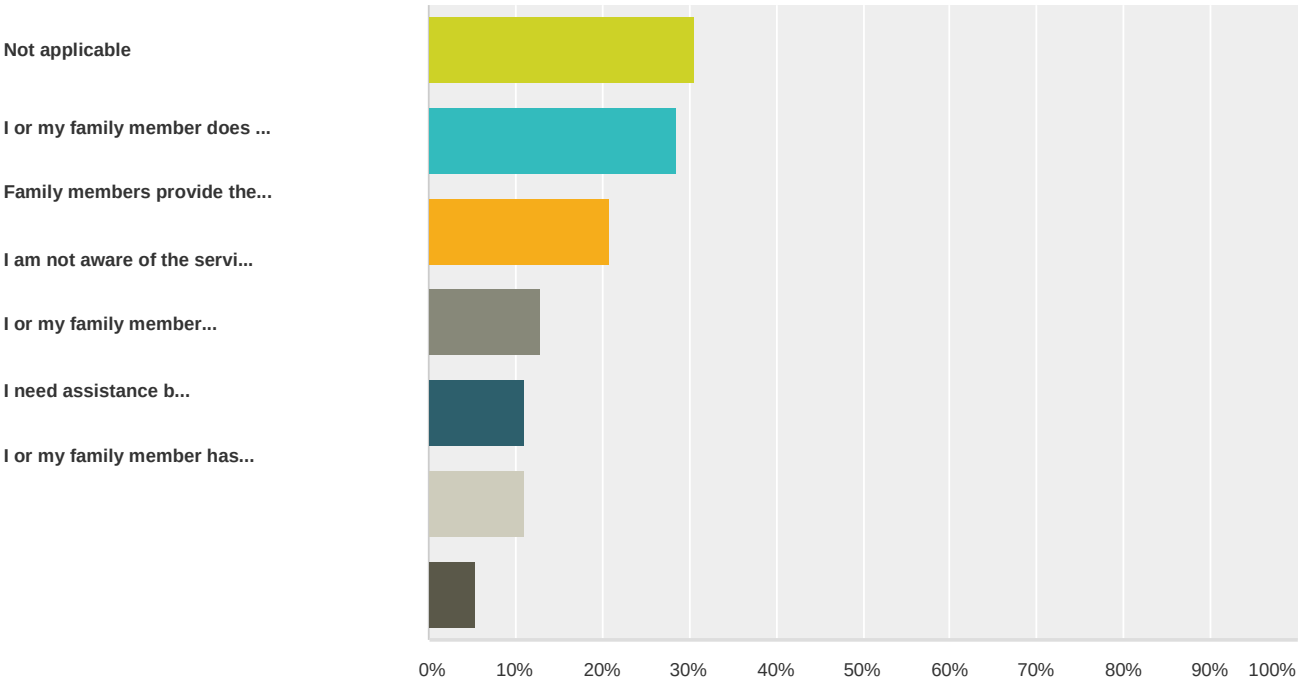
Answered: 1,190 Skipped: 66



Answer Choices	Responses	
Good	**41.09%**	489
Fair	**40.25%**	479
Poor	**9.58%**	114
Excellent	**9.08%**	108
Total		**1,190**

Q8 Please mark any of the following that apply to you or your family member:

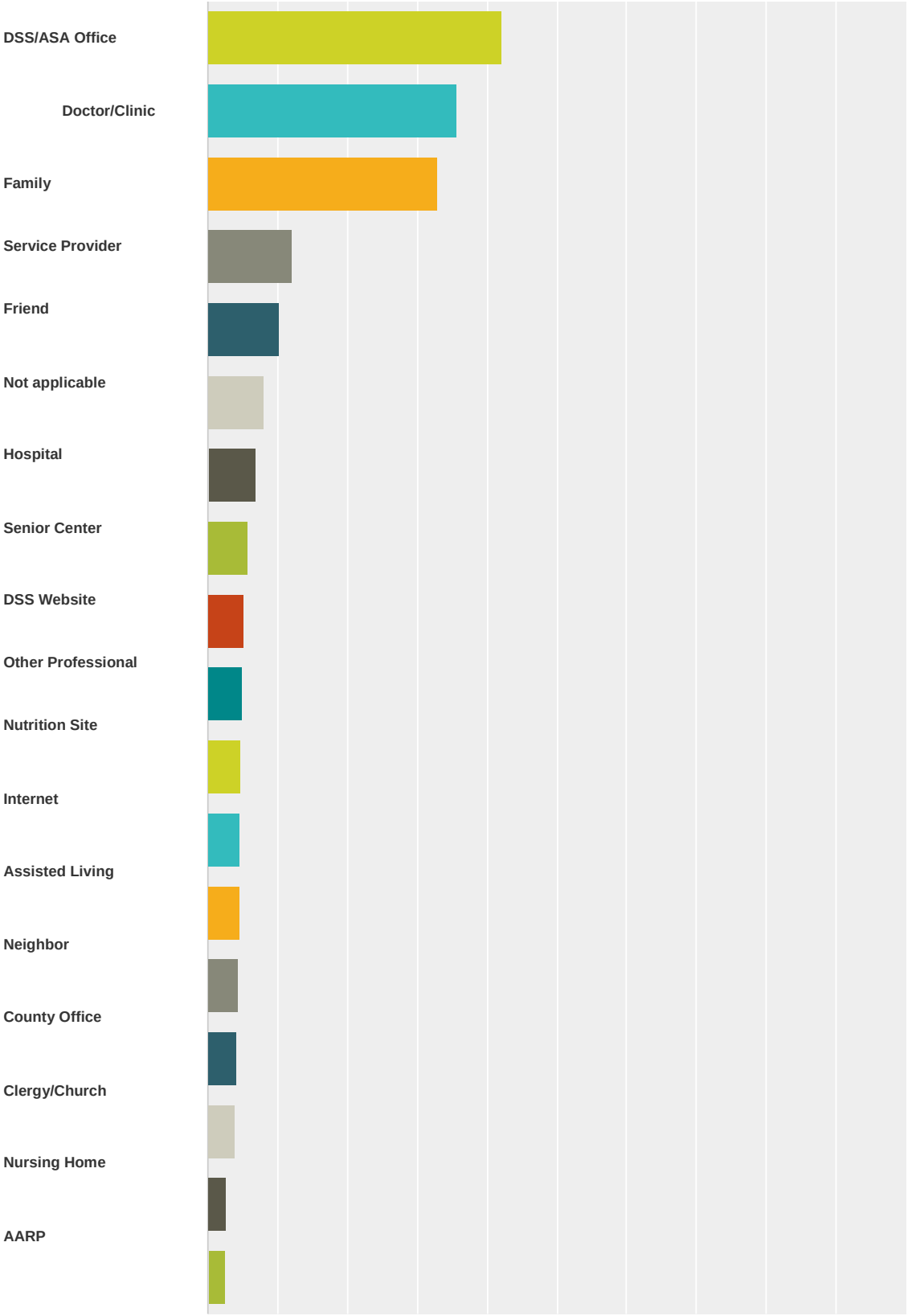
Answered: 1,176 Skipped: 80

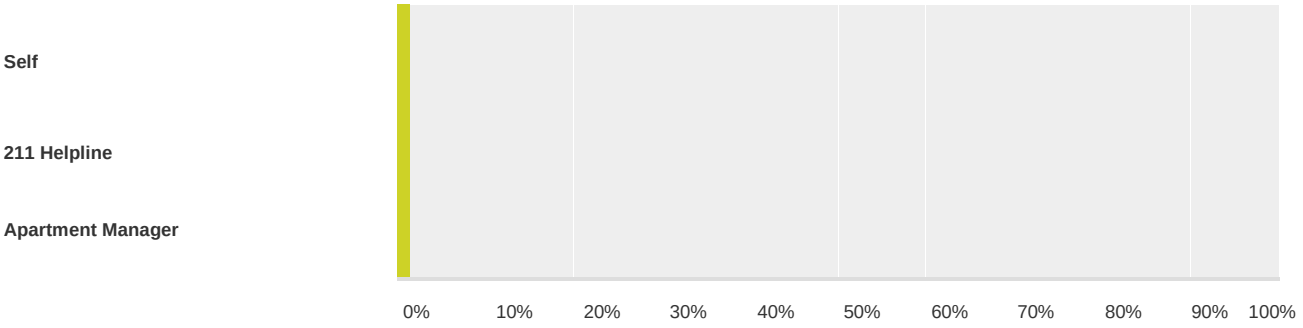


Answer Choices	Responses	
Not applicable	**30.78%**	362
I or my family member does not need in-home assistance or services.	**28.57%**	336
Family members provide the needed assistance with daily living activities.	**20.92%**	246
I am not aware of the services DSS/ASA could offer to me or my family member.	**12.93%**	152
I or my family member privately pays for all in-home services that are needed.	**11.14%**	131
I need assistance but currently I do not have anything in place.	**11.05%**	130
I or my family member has Long-term Care Insurance to meet needs.	**5.36%**	63
Total Respondents: 1,176		

Q9 If in-home services are needed in the next year, how will you obtain the information or services that you need:

Answered: 1,176 Skipped: 80

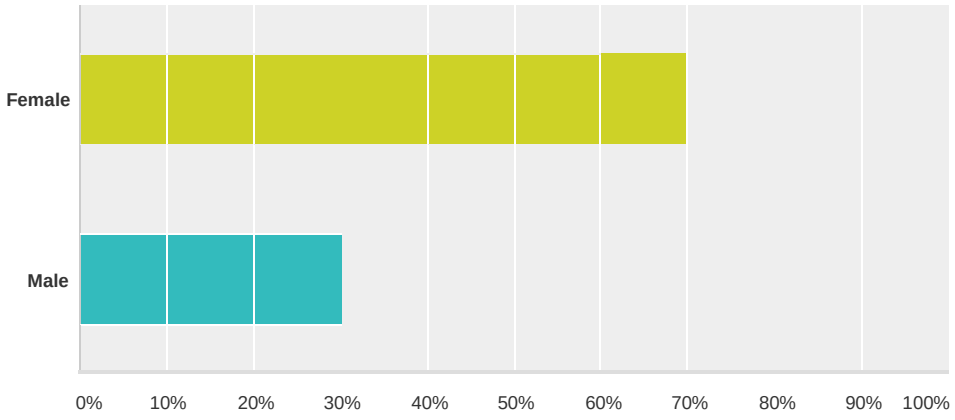




Answer Choices	Responses	
DSS/ASA Office	**42.26%**	497
Doctor/Clinic	**35.71%**	420
Family	**32.91%**	387
Service Provider	**12.07%**	142
Friend	**10.29%**	121
Not applicable	**8.08%**	95
Hospital	**6.89%**	81
Senior Center	**5.87%**	69
DSS Website	**5.19%**	61
Other Professional	**5.02%**	59
Nutrition Site	**4.76%**	56
Internet	**4.59%**	54
Assisted Living	**4.59%**	54
Neighbor	**4.42%**	52
County Office	**4.08%**	48
Clergy/Church	**4.00%**	47
Nursing Home	**2.64%**	31
AARP	**2.47%**	29
Self	**2.21%**	26
211 Helpline	**1.62%**	19
Apartment Manager	**1.62%**	19
Total Respondents: 1,176		

Q10 Sex:

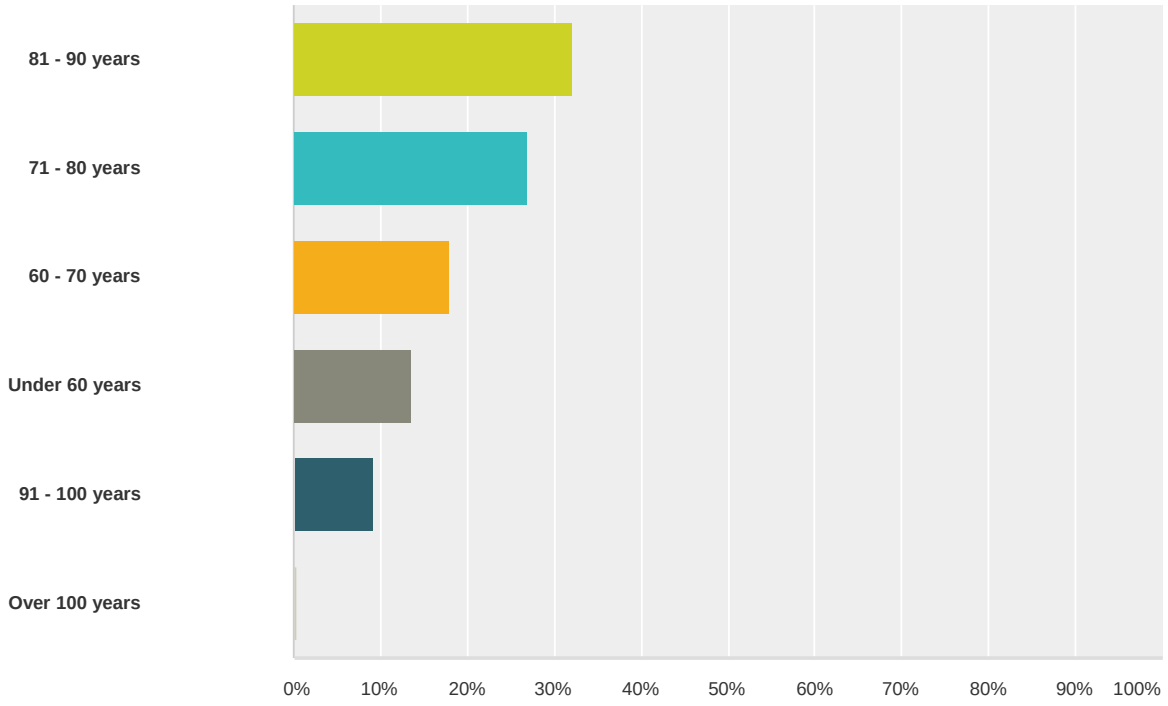
Answered: 1,169 Skipped: 87



Answer Choices	Responses	
Female	**69.03%**	807
Male	**30.97%**	362
Total		**1,169**

Q11 Age:

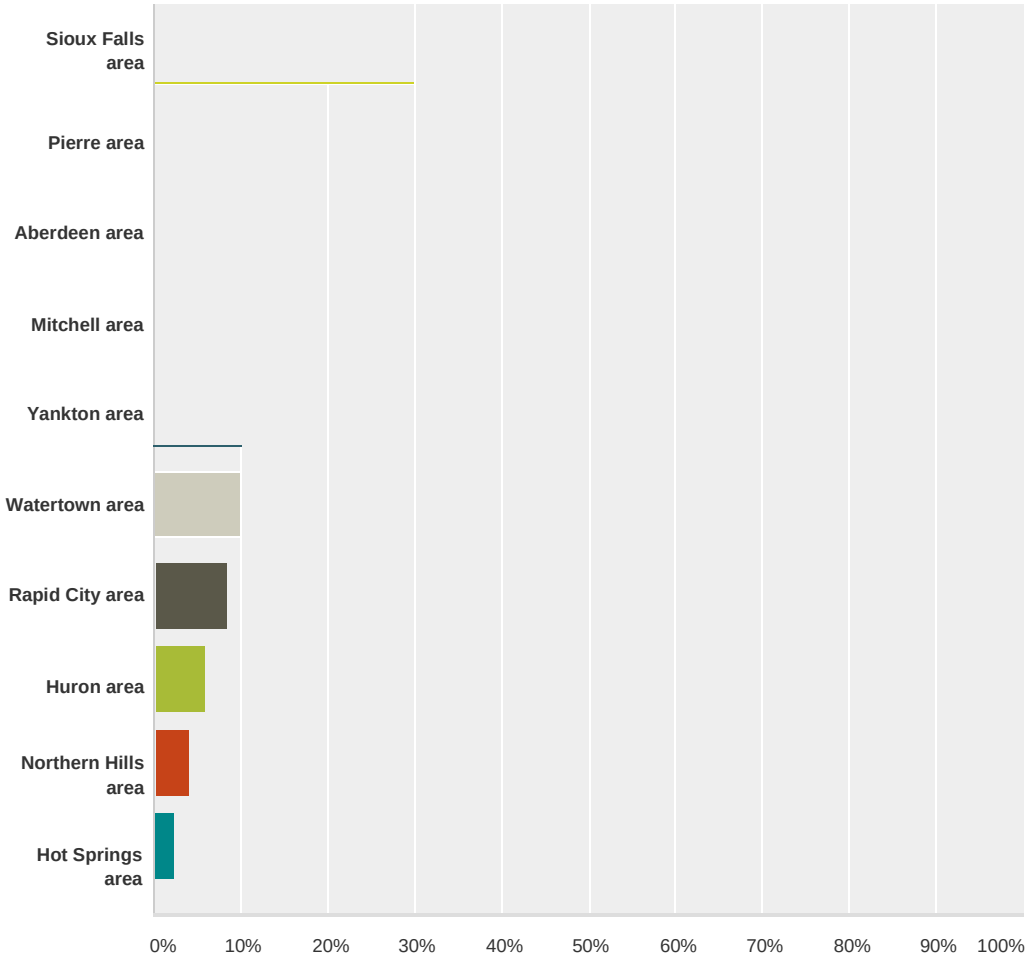
Answered: 1,169 Skipped: 87



Answer Choices	Responses	
81 - 90 years	**32.08%**	375
71 - 80 years	**26.95%**	315
60 - 70 years	**17.88%**	209
Under 60 years	**13.60%**	159
91 - 100 years	**9.15%**	107
Over 100 years	**0.34%**	4
Total		**1,169**

Q12 Geographic Location:

Answered: 1,169 Skipped: 87



Answer Choices	Responses	
Sioux Falls area	**22.50%**	263
Pierre area	**12.92%**	151
Aberdeen area	**11.46%**	134
Mitchell area	**11.38%**	133
Yankton area	**11.38%**	133
Watertown area	**9.84%**	115
Rapid City area	**8.30%**	97
Huron area	**5.82%**	68
Northern Hills area	**4.02%**	47
Hot Springs area	**2.40%**	28
Total		**1,169**

Attachment G

2015 Long Term Care Apt Study

Final Report

2015

Evaluating Long- Term Care Options for South Dakota: Update

Prepared for:
Department of Social Services
State of South Dakota Division of Adult Services and Aging
700 Governors Drive
Pierre, SD 57501

Submitted by: **Abt Associates** 55 Wheeler Street
Cambridge, MA 02138

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Executive Summary

In 2007, Abt Associates Inc. ("Abt") was commissioned by South Dakota's Department of Social Services (DSS) to assess and evaluate the State's long-term care (LTC) system. Key findings from the Final Report from that study, "*Evaluation of Long-Term Care Options for South Dakota*," were as follows:

- Rapid projected growth in the elderly and disabled elderly population was expected to drive a sharp increase in the demand for LTC services.
- Elderly population growth was anticipated to be higher in the West River than the East River region, with counties around the Sioux Falls and Rapid City metropolitan areas experiencing the most dramatic growth.
- Existing State LTC capacity was judged insufficient to meet the coming demand, with nursing homes needing to be replaced and rebalanced, and assisted living capacity, home health care services, and home and community based services (HCBS) additionally requiring expansion.
- LTC workforce growth was additionally failing to keep pace with anticipated demand.

Prior Report

Evaluation of Long-Term Care Options for South Dakota – Final Report

Released November 9, 2007

Available online at http://dss.sd.gov/news/2007/Final%20Report%20SD%20LTC%2011-9-07%20.pdf

Subsequently, in 2008, the Department of Social Services initiated a Task Force on Long Term Care Services and Supports in South Dakota to address the analysis and opportunities brought forth in the Long Term Care Report. The Task Force was charged with making recommendations towards expansion of HCBS, right-sizing the LTC system, and remedying financing issues. Stakeholders including government agencies, providers, legislators, and other interested parties met over a period of months to make recommendations for South Dakota to move forward in improving access to services. Since the Task Force released its *"Final Report - Meeting the Continuum of Care Needs of the Elderly in South Dakota"* in November 2008, the State has taken steps to complete some of the Task Force's recommendations including:

- Implementation of a "no wrong door" Aging and Disability Resource Center (ADRC);
- Passage of legislation (Senate Bill (SB) 196) to amend the existing moratorium statute to allow for expansion of beds in areas of the state identified as being in high need for additional nursing facility services through a request for proposals (RFP) process, accompanied by an update to administrative rules to coincide with the moratorium statute change, following the Task Force's criteria for access critical designations; and
- Implementation of the Money Follows the Person rebalancing demonstration.

Other notable initiatives in recent years include:

- Renewal and expansion of the Adult Services and Aging (ASA) HCBS waiver;
- Establishment of a Medicaid Solutions Workgroup focused specifically on HCBS to develop recommendations on different service models to meet the needs of individuals requiring supports

and services in the least restrictive and most appropriate environment, analyze opportunities available through the federal government, and explore reimbursement models;

- Convening of a Dementia Care Workgroup to address concerns about Assisted Living regulations; and
- Adoption of the Health Homes model to serve South Dakotans with chronic conditions or behavioral health conditions.

It is in this changing policy context that the Department of Social Services has commissioned Abt to perform an update of selected analyses from the 2007 report. In particular, using up-to-date data collected since the release of the prior report, we have performed the following tasks:

Task 1: Updating Demographic Trend Challenges. Under this task, we updated projections of trends in the State elderly and disabled population over the next 20 years (through 2035), updating and extending the projections through the year 2025 appearing in Section 4.1.1 of the prior report.

Task 2: Updating Service Delivery Challenges. Under this task, we examined geographic variation in the distribution of LTC services across the State, including nursing homes, assisted living, home health, and HCBS. These analyses provide updated snapshots that may be directly compared to those appearing in Section 4.2 of the prior report.

Task 3: Projecting Future Demand for Long-Term Care Services. Finally, under this task we analyzed several alternative scenarios for future growth in demand for LTC services, particularly focused on identifying areas with the highest projected future unmet need. These analyses update parallel scenarios reported in Section 4.4 of the prior report.

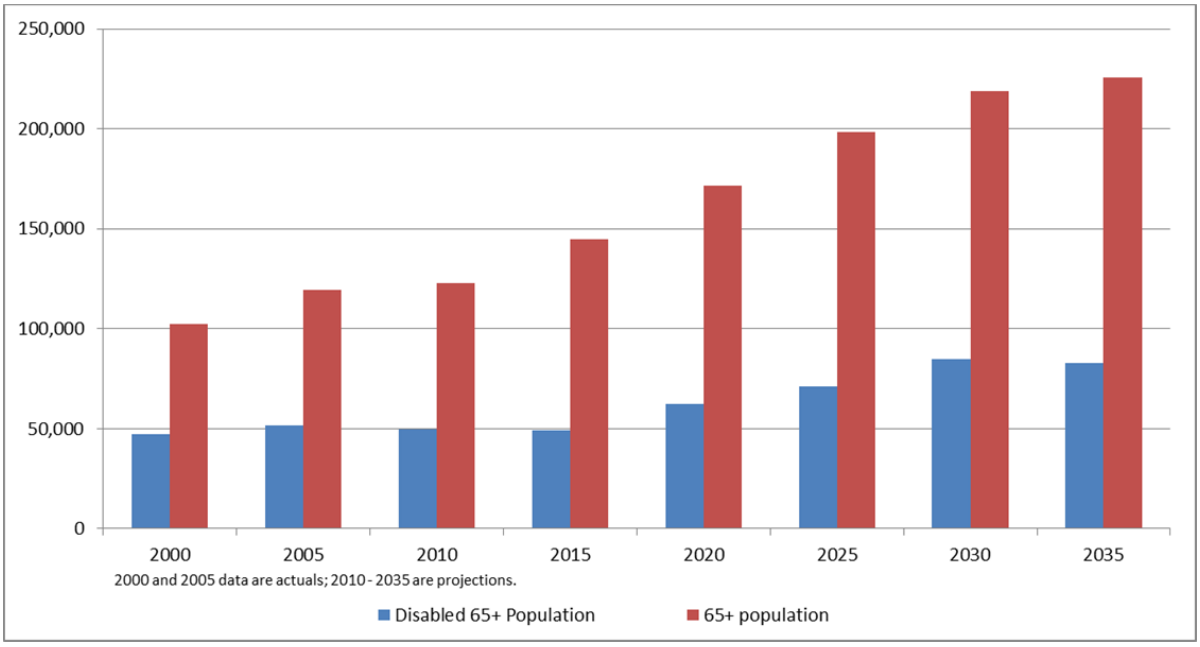
Demographic Trend Challenges

Exhibit E-1 (next page) shows actual population totals for 2000-2010 accompanied by updated population projections through the year 2035.

Through the 2010 decennial Census, actual growth in the elderly and elderly disabled populations was somewhat lower than projections in the prior report. Accordingly, the South Dakota State Data Center has revised projected growth rates modestly downward since that time. Based on these revised estimates, we now project that:

- The number of elders (over age 65) will increase by about 84 percent in the year 2035 relative to decennial Census totals in the year 2010, increasing by approximately 103,000 to 226,000.
- The number of disabled elders will peak in 2030, increasing by about 33,000 to 85,000, or 71 percent higher than the decennial Census year 2010 total; by 2035, this number will fall slightly as the relative proportion of younger elderly individuals (aged 65-74) increases in relation to the proportion of older elderly individuals (aged 75+).

Exhibit E-1. Projections of South Dakota's Elderly and Disabled Population (2000-2035)



Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, 2010 and American Community Survey.

Although projected growth in the elderly population overall has slowed relative to past projections, it remains the case that growth rates and associated demand for LTC services are not evenly balanced across the State. Local LTC services will be stressed both by growth in the numbers of seniors as well as by high rates of growth in demand for care. Overall, the geographic variation in growth rates across Economic Assistance Regions in this updated report is similar to that seen in the prior report. In particular:

- Growth rates for the elderly and disabled elderly population are again projected to be greater in West River (Regions 1 and 2) than East River (Regions 5 through 8).
- The regions including the Sioux Falls metropolitan area (Region 8) and the Rapid City/Northwest counties (Region 1) continue to exhibit the fastest rates of anticipated growth, as well as the largest growth in the overall numbers of elders. However, as with total projected Statewide growth, overall growth rates from 2010 to 2035 are now projected to be more moderate than those previously projected for Regions 1 and 8 for the years 2000 to 2025 in the prior report.
    - Specifically, the Region 1 elderly population was previously projected to grow by 250 percent from 2000 to 2025; updated projections now indicate a 110 percent increase from 2010 to 2035.
    - For Region 8, the elderly population was projected to increase 235 percent from 2000 to 2025, as compared to a 170 percent increase from 2010 to 2035 in the updated projections.
- Growth in both Region 1 and Region 8 continues to be fueled by the migration of seniors from frontier areas towards urban areas and medical centers.

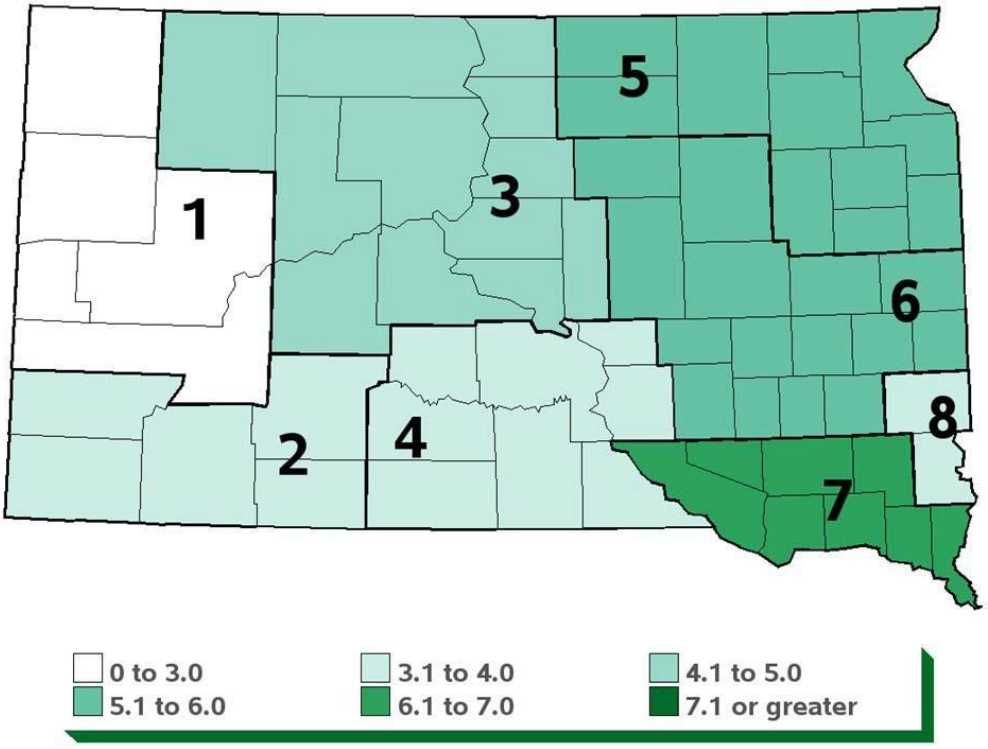
- In 2000, there were 22 counties where the elderly population exceeded 20 percent of total residents in the county. By 2010, there were 42 counties where the elderly population exceeded 20 percent of total residents.
- By 2035, in all but 10 South Dakota counties elders will make up over 20 percent of the population. In 27 counties, elders will be over 40 percent of the local population. Even in the growing population centers, around Sioux Falls and Rapid City, elders will make up 29-30 percent of residents.

Service Delivery Challenges

We gathered updated information to describe recent trends in delivery of LTC services, including nursing homes, assisted living, home health, and home and community-based services (HCBS).

Nursing Homes. Nursing home capacity and utilization rates have continued to drop both in South Dakota and nationwide since the release of the final report. In 2006, the most recent data available for the prior report, South Dakota ranked tenth in the nation in terms of nursing home utilization, with 61 licensed beds per 1,000 elders. By 2011, that number had dropped substantially to 48 licensed beds per 1,000 elders, sixteenth nationwide. Though South Dakota's utilization rates remain higher than national averages, the drop in utilization between 2006 and 2011 indicates that the gap is shrinking.

Exhibit E-2. Number of Licensed Beds in Use per 100 Elderly Individuals, South Dakota, 2014



Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data; South Dakota's Nursing Facilities Data, and Nursing Home Compare.

The number of licensed nursing facility beds in use per 100 elderly individuals has declined slightly from 2003-2005 levels, with a minimum of 2.6 beds in use per 100 elderly individuals in Economic Assistance Region 1 and a maximum of 6.4 beds in use per 100 elderly individuals in Economic Assistance Region 7. As in the prior report, utilization rates are substantially higher in the East River regions (5 through 8) than in the West River regions (1 and 2).

Assisted Living. Relative to other states, South Dakota ranked 16th for available assisted living beds in 2010, at 3.4 available beds per 100 elderly individuals. This represents a slight increase in the number of available beds from roughly 3 per 100 elderly individuals in 2004, which placed South Dakota 15th among the states at that time. All regions of the State displayed growth in the total number of assisted living beds since the last report, but substantial geographic variation remains.

Home Health Care. South Dakota continues to have the 2nd fewest Medicare skilled home health episodes of the 50 states, with just over 5 episodes per 100 elderly individuals. There is little evidence of a shift in geographic patterns in Medicaid- and Medicare-certified home health agencies or visits since the prior report.

Home and Community-Based Care. Home and community based services are a critical support component to allow elders to remain in the community as long as possible. Since the prior report, we do not see evidence of perceptible shifts in availability of home and community based services in South Dakota: adult day facilities, senior centers, nutrition programs, homemaker services, and in-home service clients all remain at similar, relatively low levels.

Projecting Future Demand for Long-Term Care Services

Based on the most recent available data, we estimate that, since the year 2000, nursing home utilization rates as a percentage of the elderly population in South Dakota have declined from 6.4 percent to 4.7 percent (2010-2014 average). This compares to a somewhat slower nationwide decline from 4.2 percent to 3.2 percent over approximately the same interval. Our projections of future demand for LTC services extrapolate from recent State trends to characterize demand under several different possible future scenarios for nursing home utilization.

- Scenario A: Our baseline projections assume that nursing home utilization rates persist at recent levels. In particular, we assume that the nursing home utilization rate will **remain at its 2010-2014 average level of 4.7 percent of the elderly population**.

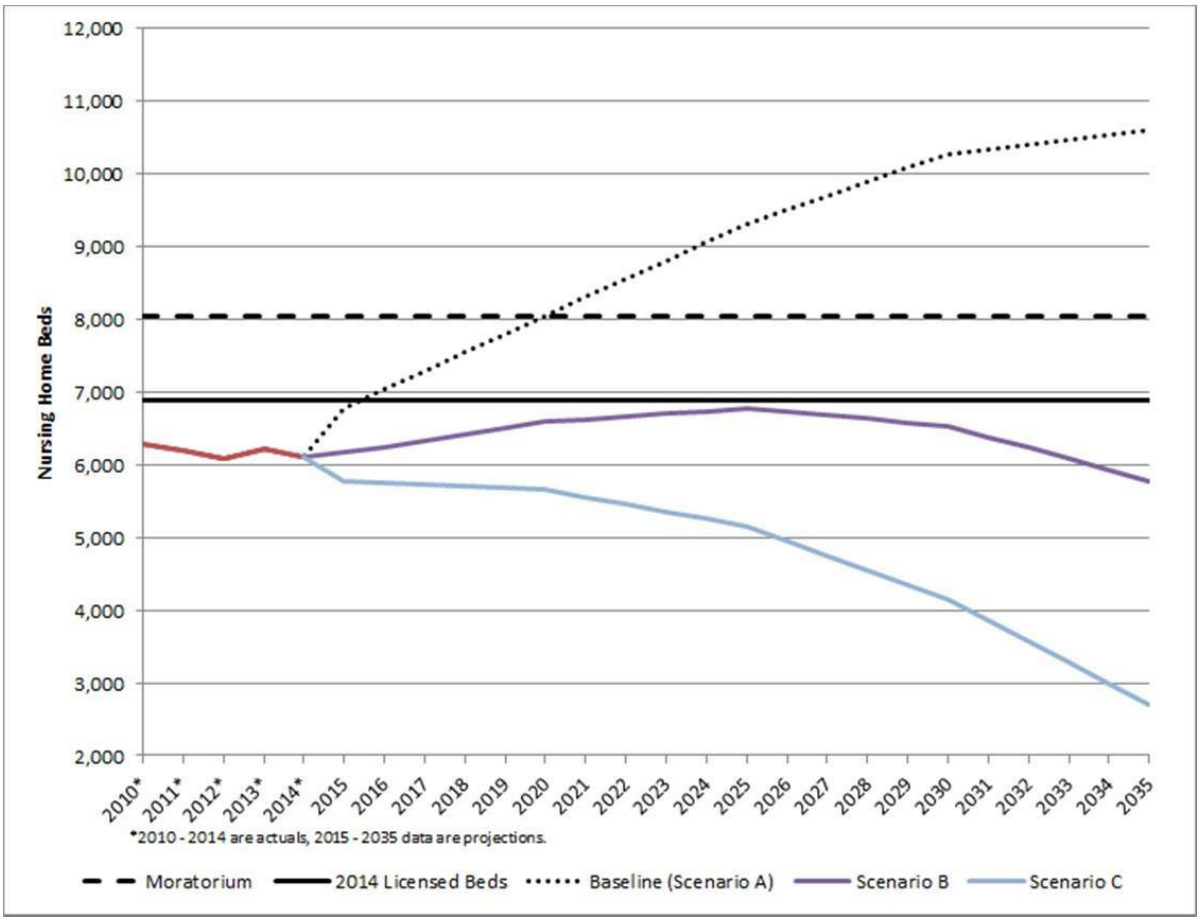
This projection scenario methodology mirrors the baseline projections provided in the 2007 Final Report to enable direct comparison. However, we note that, given the recent sharp decline in nursing home utilization in South Dakota as described above, it appears unlikely that future utilization rates will in fact remain fixed at this level as assumed. The two alternative future scenarios considered below, which assume continued declines in utilization rates moving forward, may therefore more realistically depict actual future trends.

- Scenario B: Under the first alternative future scenario we consider, we assume that the recent steep decline in nursing home utilization rates in South Dakota relative to national trends will moderate somewhat in coming years. In particular, we assume that the nursing home utilization rate will **decline by 0.09 percentage points per year, or approximately one half the 2000-2014 rate of decline**.

- Scenario C: Under the second alternative future scenario we consider, we assume that nursing home utilization rates in South Dakota will continue to decline more steeply than recent national trends, ultimately converging to national average rates by 2035. In particular, we assume thatthe nursing home utilization rate will **decline by 0.14 percentage points per year, reaching a rate of 1.2 percent by 2035**.

Nursing Homes. Exhibit E-3 shows projections for total nursing home population for each scenario. Under the baseline scenario, the nursing home population continues to rise through 2035 with the increase in the elderly and elderly disabled populations, but under the two alternative scenarios the population is actually forecast to *decrease* by 2035. These projected decreases occur when the declining utilization rate falls far enough to compensate for the continued increase in the elderly and disabled elderly populations. In particular, under Scenario B, the projected nursing home population reaches a maximum of 6,776 in the year 2025 before declining to 5,776 in 2035; under Scenario C, the projected nursing home population declines continually from its current level to reach 2,709 in 2035.

Exhibit E-3. Forecast Number of South Dakota Nursing Home Beds, 3 Scenarios, 2000 – 2035



Source: Abt Associates' analysis of South Dakota's Nursing Facilities Data and South Dakota Department of Social Services' Nursing Home Occupancy Report.

Assisted Living. Under our two alternative scenarios, the decline in nursing home utilization is partially offset by an increase in assisted living utilization. Under Scenario B, our mid-point forecast, assisted living utilization rates would rise from 2.6% in the year 2000 to 3.6% in 2035. Under the baseline Scenario A, projected demand for beds will only marginally exceed supply so long as capacity continues to increase in line with its recent 1.5% annual trend; from 2025 to 2030 projected demand is just slightly higher than projected capacity, but by 2035 the gap closes once more. However, if nursing home utilization rates decline consistent with our more reasonable assumptions under the two alternative scenarios, demand for assisted living beds will exceed supply well before 2020.

Home and Community-Based Services. As in our prior report, in all scenarios considered, the numbers of community-dwelling disabled seniors will increase, driven by population changes, higher projected health levels, individual preferences, or policy changes that could promote increases in home and community based care options. However, we see little evidence of substantial increases in provision of HCBS relative to levels observed in our 2007 report, and South Dakota continues to lag behind national averages. It is clear that further aggressive rebalancing efforts will be required to support increasing numbers of community-dwelling seniors in the future.

Conclusions

It is clear that recent policy changes in South Dakota have successfully accelerated the decline in nursing home utilization, substantially reducing the gap relative to national utilization rates. Assisted living utilization has increased in parallel, but we do not observe concurrent increases in skilled Medicare home health or HCBS.

These results naturally lead to speculation on how the needs of individuals are being met in light of decreasing nursing home utilization without a correlating increase in the use of formal supports. Per the Department of Social Services, South Dakota ranked within the top five states nationwide in market penetration for private long term care insurance as of June 2013, potentially indicating one way in which residents are bridging the gap. Increased use of informal supports by family and friends may also play a role, though we cannot formally assess this possibility in the context of this report.

Under all hypothetical future scenarios considered, further efforts will be required to meet future demand for LTC services outside the nursing home setting. The State must clearly maintain its focus on rebalancing the long-term services and supports systems (LTSS), through:

- Continuing to utilize options counseling through the ADRC to educate consumers and families about community-based care alternatives, in attempts to reduce nursing home admissions;
- Continuing to expand and enhance the availability of HCBS and potentially State Plan-funded community-based care; and
- Exploration of the care preferences and knowledge base of elders and their caregivers, as well as gathering information on the informal support networks that people are currently utilizing in lieu of seeking assistance from state programs.

1. Introduction

In 2007, Abt Associates Inc. ("Abt") was commissioned by South Dakota's Department of Social Services (DSS) to assess and evaluate the State's long-term care (LTC) system. Key findings from the Final Report from that study, "*Evaluation of Long-Term Care Options for South Dakota*," were as follows:

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- Implementation of a "no wrong door" Aging and Disability Resource Center (ADRC);
- Passage of legislation (Senate Bill (SB) 196) to amend the existing moratorium statute to allow for expansion of beds in areas of the state identified as being in high need for additional nursing facility services through a request for proposals (RFP) process, accompanied by an update to administrative rules to coincide with the moratorium statute change, following the Task Force's criteria for access critical designations; and
- Implementation of the Money Follows the Person rebalancing demonstration.

Other initiatives also bear mentioning. A Medicaid Solutions Workgroup convened during the 2011 Legislative Session to engage stakeholders to provide input and develop strategies to manage Medicaid expenditures in South Dakota and to develop recommendations to enhance the Medicaid program. The workgroup focused specifically on HCBS to develop recommendations on different service models to meet the needs of individuals requiring supports and services in the least restrictive and most appropriate environment, analyze opportunities available through the federal government,

and explore reimbursement models. The State has since implemented Money Follows the Person (as noted above) to help recipients of Medicaid transition from long-term care institutions to HCBS. Additionally, South Dakotans with chronic conditions or behavioral health conditions are now eligible to receive Health Home services through the creation of the Health Homes model.

In addition, the renewal of the Adult Services and Aging (ASA) Home and Community Based Services Waiver in October 2011 included an expansion to offer additional services of adult companionship and environmental accessibility adaptations. These services enable individuals to function with greater independence within their home.

Finally, a Dementia Care Workgroup convened following the 2013 Legislative Session to address concerns about Assisted Living regulations. The South Dakota Department of Health recently initiated the formal rules process to amend administrative rules regarding assisted living centers. The proposed changes would allow assisted living centers to admit and retain residents requiring dining assistance or needing additional staff for up to total assistance to complete activities of daily living or to turn or raise in bed and to transfer.

It is in this changing policy context that the Department of Social Services has commissioned Abt to perform an update of selected analyses from the 2007 report. In particular, using up-to-date data collected since the release of the prior report, we have updated forecasts of demographic trends in the elderly and disabled elderly population; descriptive findings on the current state of service delivery; and projected future demand for LTC services. In the remainder of this report, we first briefly describe study methods. We then summarize the results of these updated analyses, including a comparison with prior findings where relevant. We then conclude with a brief discussion of potential policy implications.

2. Methods

Abt Associates was contracted by the State to update analyses to assess and evaluate South Dakota's LTC system needs through the following three tasks.

Task 1: Updating Demographic Trend Challenges. Under this task, we updated projections of trends in the State elderly and disabled population over the next 20 years (through 2035), updating and extending the projections through the year 2025 appearing in Section 4.1.1 of the prior report.

Task 2: Updating Service Delivery Challenges. Under this task, we examined geographic variation in the distribution of LTC services across the State, including nursing homes, assisted living, home health, and HCBS. These analyses provide updated snapshots that may be directly compared to those appearing in Section 4.2 of the prior report.

Task 3: Projecting Future Demand for Long-Term Care Services. Finally, under this task we analyzed several alternative scenarios for future growth in demand for LTC services, particularly focused on identifying areas with the highest projected future unmet need. These analyses update parallel scenarios reported in Section 4.4 of the prior report.

In the remainder of this section, we describe the methodology and data sources for each of these three tasks in greater detail.

2.1 Task 1: Updating Demographic Trend Challenges

The elderly and the disabled are the two population cohorts most relevant for understanding South Dakota's future LTC needs. Our population projections include noninstitutionalized elderly and disabled individuals residing in the community or in assisted living facilities, as well as institutionalized elderly and disabled residing in nursing homes.

Noninstitutionalized Elderly Population Projections. Estimates of the 2010 noninstitutionalized elderly population come from the decennial U.S. Census. Our projections of growth in the noninstitutionalized elderly population through 2035 are based on data from the South Dakota State Data Center, as in the prior report.

In updating our analyses, we additionally reviewed population projections from the U.S. Census as a possible alternative data source; however, the Census program (Interim State Population Projections) to develop population projections at the county level was discontinued in 2005, so up-to-date county-level projections were not available. We therefore elected to continue using the South Dakota State Data Center projections.

We note, that, consistent with our review of data sources for the prior report, the State Data Center projections predict a higher rate of population growth in the elderly population for the state as a whole than do the Census projections. In particular, Census estimates project a 71 percent increase in the population aged 65 years or older between 2010 and 2035, as compared to a projected 89 percent increase in the State Data Center figures. For 2010, actual decennial Census elderly population totals for the State were approximately midway in between the older Census and State Data Center projections as cited in our prior report; while we cannot draw firm conclusions from this single data

point, it seems reasonable to consider the State Data Center projections as a likely upper bound on anticipated population growth.

Institutionalized Elderly Population Projections. 2008-2014 data on nursing home occupancy provided by South Dakota formed the base for our projections of the institutionalized elderly population. Trends in nursing home average daily census over that interval were extrapolated to produce estimates of the institutionalized population through 2035.

Disability Rates for Noninstitutionalized Population. We calculated the disability rate for the noninstitutionalized population by gathering disabilities data from 2008-2012 5-year American Community Survey (ACS) Summary File. The ACS provides estimates of disability rates separately for females 65-74, females 75+, males 65-74, and males 75+.

Note that disability estimates for our prior report were drawn from the 2000 decennial Census. The 2010 decennial Census no longer provides disability estimates at the county level. For this reason, we have turned to the ACS as an alternative data source for up-to-date disability estimates. Disability rates from the ACS for the noninstitutionalized elderly population range from 37-38 percent, as compared to the 43 percent rate from the 2000 Census as used in the prior report.

We applied the ACS disability rates to the population counts from corresponding age category and gender groups from the State Data Center projections to obtain projections of the total number of noninstitutionalized disabled by county. Note that this method implicitly assumes that disability rates within each age group and gender category will remain constant through 2035.

Our projections of the disabled population also include estimates of the assisted living population extrapolated from 2003-2005 Health Care Facilities reports and 2014 Assisted Living bed count survey data provided by South Dakota.

Disability Rates for Institutionalized Population. In the prior 2007 report, we assumed a 96 percent disability rate among nursing home residents, based on the 2004 National Nursing Home Survey (NNHS). Since the NNHS is no longer updated, for this report we have instead used data from the Center for Medicare & Medicaid Services (CMS) Nursing Home Compare website on disability rates in South Dakota nursing homes. In particular, we now assume a disability rate of 74 percent based on the average proportion of South Dakota nursing home residents requiring assistance with one or more activities of daily living (ADL) in 2011-2013. We applied this rate to the institutionalized population projections from the Nursing Home Facility data to obtain counts of the disabled institutionalized population by county.

Summary. For quick reference, the summary table below provides an overview of data for our population projections under this task.

Data Source	Description
South Dakota State Data Center	65+ noninstitutionalized population projections
American Community Survey	Noninstitutionalized population disability rates
Nursing Home Occupancy Reports (2008-2014)	Institutionalized population
CMS Nursing Home Compare (2009-2013)	Institutionalized population disability rates
South Dakota DSS Survey Data (2014)	Assisted Living Facilities population (2014)
South Dakota Facilities Reports (2003-2005)	Assisted Living Facilities population (2003-2005)

2.2 Task 2: Updating Service Delivery Challenges

To analyze service delivery challenges, we assessed the availability of and need for services in nursing homes, assisted living, home health, and home and community-based services.

Nursing Homes. To compare South Dakota nursing home utilization rates to national rates, we utilized 2011 (the most recent) data available from the Kaiser Family Foundation[1] to determine the number of nursing home beds in each state. We calculated the utilization rate by dividing by the elderly population – 65 and over – in each state from the American Community Survey 2011 1-year dataset.

We also relied upon 2008 – 2014 Nursing Home occupancy data and 2009 – 2012 Nursing Facility Patient Origin data provided by South Dakota to estimate licensed beds in use, maximum licensed beds, and nursing home travel patterns. South Dakota also provided data on nursing home case mix and current moratorium beds.

Assisted Living. We utilized Assisted Living Center survey data provided by South Dakota to identify licensed assisted living beds by county.

Home Health. To compare South Dakota's home health episodes to national figures, we used summary administrative data on Medicare home health visits from the CMS Chronic Conditions Data Warehouse (CCW) as provided by the Centers for Disease Control and Prevention (CDC) Health Indicators Warehouse. Medicaid- and Medicare certified home health agencies serving each South Dakota county were identified using data from Home Health Compare.

Adult Day Services. We accessed South Dakota's Department of Social Services website to identify adult day services available by county.

Senior Citizens Centers, Adult Nutrition Programs, and In-Home Providers. South Dakota provided us with a recent list (April 2014) of Senior Citizens Centers in South Dakota as well as data on Nutrition Programs and unduplicated In-Home Providers.

Summary. For quick reference, the summary table below provides an overview of data sources for our descriptive analysis of service delivery challenges.

Data Source	Description
CDC Health Indicators Warehouse	Medicare Home Health Episodes by State
Adult Day Services (DSS website)	Adult Day Services by County
American Community Survey	Elderly Population by State
South Dakota DSS Survey Data	Licensed Assisted Living Beds
Home Health Compare	Medicaid- and Medicare-Certified Home Health Agencies
Kaiser Family Foundation	Nursing Home Utilization Rates by State
Nursing Facility Patient Origins (provided by DSS)	Nursing Home Travel Patterns
Nursing Home Compare	Nursing Facility Case Mix

[1] Accessible at http://kff.org/other/state-indicator/number-of-nursing-facility-beds/.

Data Source	Description
Nursing Home Occupancy Reports (2008-2014)	Licensed beds in use, maximum licensed beds
Senior Citizens Centers, Adult Nutrition Programs, Homemaker Agencies, and In-Home Provider consumers (provided by DSS)	Home and community based services provider by county; listing of homemaker agencies is made up of those agencies with an established relationship with the State to provide home health services and is not an all-inclusive list.

2.3 Task 3: Projecting Future Demand for Long-Term Care Services

Under Task 3, we project future demand for LTC services based on projections of the elderly and disabled elderly population as produced under Task 1, and extrapolations from recent LTC service utilization levels and trends as described under Task 2.

Nursing Home Utilization. Based on the most recent available data, we estimate that, since the year 2000, nursing home utilization rates as a percentage of the elderly population in South Dakota have declined from 6.4 percent to 4.7 percent (2010-2014 average). This compares to a somewhat slower nationwide decline from 4.2 percent to 3.2 percent over approximately the same interval.[2] Our projections of future demand for LTC services extrapolate from recent State trends to characterize demand under several different possible future scenarios for nursing home utilization.[3]

- Scenario A: Our baseline projections assume that nursing home utilization rates persist at recent levels. In particular, we assume that the nursing home utilization rate will **remain at its 2010-2014 average level of 4.7 percent of the elderly population**.

This projection scenario methodology mirrors the baseline projections provided in the 2007 Final Report to enable direct comparison. However, we note that, given the recent sharp decline in nursing home utilization in South Dakota as described above, it appears unlikely that future utilization rates will in fact remain fixed at this level as assumed. The two alternative future scenarios considered below, which assume continued declines in utilization rates moving forward, may therefore more realistically depict actual future trends.

- Scenario B: Under the first alternative future scenario we consider, we assume that the recent steep decline in nursing home utilization rates in South Dakota relative to national trends will moderate somewhat in coming years. In particular, we assume that the nursing home utilization rate will **decline by 0.09 percentage points per year, or approximately one half the 2000-2014 rate of decline**.
- Scenario C: Under the second alternative future scenario we consider, we assume that nursing home utilization rates in South Dakota will continue to decline more steeply than recent national trends, ultimately converging to national average rates by 2035. In particular, we assume that the

[2] National utilization data are only available through the year 2012.

[3] Note that, unlike demand scenarios in the prior Final Report, these projections extrapolate from both recent State trends and national trends. In this sense, these projections represent an improvement over those from the prior report, for which data availability limited our ability to make use of more relevant State-level data.

nursing home utilization rate will **decline by 0.14 percentage points per year, reaching a rate of 1.2 percent by 2035**.

Assisted Living Utilization. Under the baseline scenario (Scenario A), utilization of assisted living is also assumed to continue at its current 2010-2014 average level, or 2.6 percent of the elderly population. Under the two alternative scenarios, in contrast, assisted living demand is assumed to rise as a greater proportion of elders and disabled elders seek alternative LTC services. In particular, we assume that one half of individuals residing in nursing homes under the baseline scenario who no longer reside in nursing homes under each alternative scenario instead seek assisted living services, while the other half remain in the community.

Disability Rates. Our estimates of disability rates rely on existing data on current disability rates in each setting. In particular, for nursing homes, we use data from 2011-2013 as reported by Nursing Home Compare to estimate the current distribution of limitations in activities of daily living (ADLs) in South Dakota nursing homes. For assisted living, we assume that the current distribution of ADL limitations in South Dakota assisted living facilities is consistent with national data from the Centers for Disease Control and Prevention (CDC) National Survey of Residential Care Facilities (NSRCF) for 2010, the most recent available data.

Under the baseline scenario, the distribution of ADL limitations in each setting is then assumed to remain constant over time. Under the two alternative scenarios, we assume that those individuals residing in nursing homes under the baseline scenario who no longer reside in nursing homes under the alternative scenarios will be comprised of individuals with the highest functional status. That is, individuals with 0 or 1 ADL limitations will be the first to exit nursing homes to seek alternative care, followed by those individuals with 2 ADL limitations, and so on.

Comparing Supply and Demand. Finally, under each scenario, we compare projected future demand to existing supply at the county level in order to characterize gaps and excesses. For nursing homes, we assume supply is limited at current moratorium levels in each county, though as noted above we are aware that, in practice, SB 196 permits the Department of Health to reallocate beds across nursing homes, and recent changes to administrative requirements allow the Department to solicit proposals from facilities to address unmet nursing home or nursing home bed needs in select areas. For assisted living, we assume that supply will increase by approximately 1.5 percentage points per year, consistent with our assumption in the prior report and in line with recently observed trends.

Summary. For quick reference, the summary table below provides an overview of data sources for our projections of future demand for LTC services

Data Source	Description
South Dakota State Data Center	65+ noninstitutionalized population projections
American Community Survey	Noninstitutionalized population disability rates
Nursing Home Facilities Files (provided by DSS)	Licensed nursing home beds in use (2000-2014)
Assisted Living Facilities Files (provided by DSS)	Licensed assisted living beds in use (2000-2014)
Nursing Home Compare	ADL limitations in South Dakota nursing homes
National Survey of Residential Care Facilities	ADL limitations in assisted living facilities

3. Demographic Trend Challenges

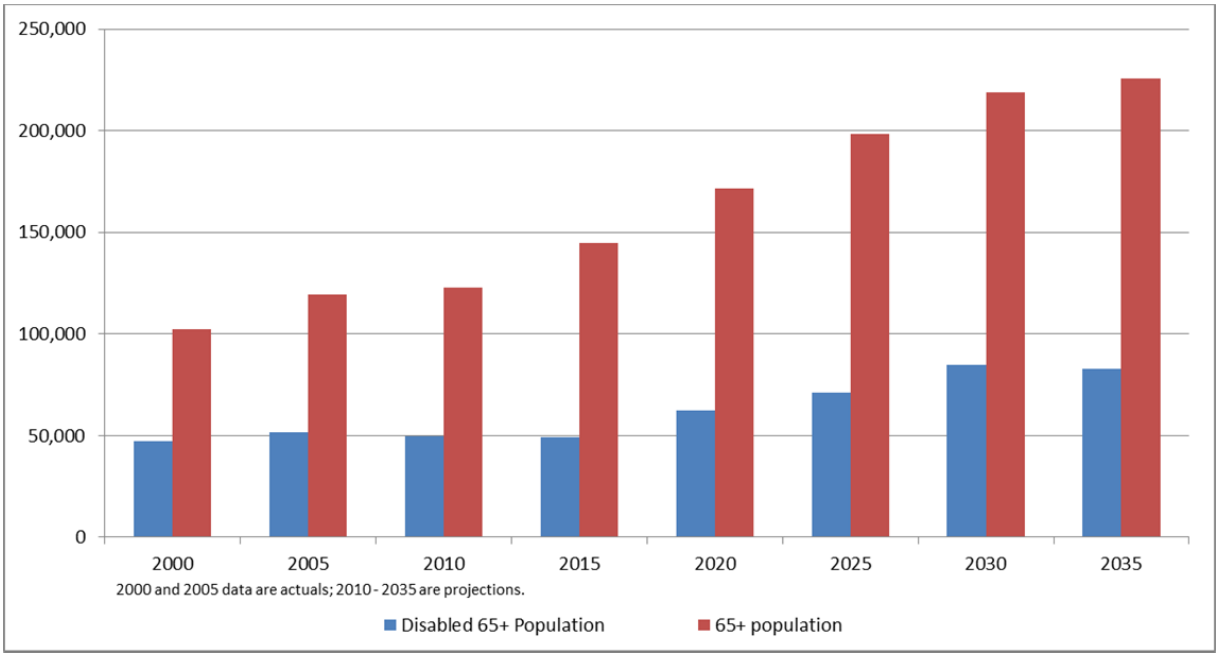
In this section, we describe updated projections of the elderly and elderly disabled populations in South Dakota through 2035, including a comparison to projections through 2025 as appearing in our prior 2007 report.

3.1 Statewide Population and Disability Rates

In the 2007 report, we projected a sharp increase in the demand for LTC services in South Dakota, driven by an increase in the number of individuals and disabled individuals over age 65. In particular, based on South Dakota State Data Center population projections, we previously anticipated an increase of roughly 100,000 elders between 2000 and 2025, paired with an increase of 50,000 or slightly fewer disabled elders over the same time period.

Exhibit 1 shows actual population totals for 2000-2010 accompanied by updated population projections through the year 2035.

Exhibit 1. Projections of South Dakota's Elderly and Disabled Population (2000-2035)



Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, and American Community Survey.

Through the 2010 decennial Census, actual growth in the elderly and elderly disabled populations was somewhat lower than projections in the prior report. Accordingly, the South Dakota State Data Center has revised projected growth rates modestly downward since that time. Based on these revised estimates, we now project that:

- The number of elders (over age 65) will increase by about 84 percent in the year 2035 relative to decennial Census totals in the year 2010, increasing by approximately 103,000 to 226,000.

- The number of disabled elders will peak in 2030, increasing by about 33,000 to 85,000, or 71 percent higher than the decennial Census year 2010 total; by 2035, this number will fall slightly as the relative proportion of younger elderly individuals (aged 65-74) increases in relation to the proportion of older elderly individuals (aged 75+).

3.2 Geographic Variation in Population Growth

Although projected growth in the elderly population overall has slowed relative to past projections, it remains the case that growth rates and associated demand for LTC services are not evenly balanced across the State.

As in the prior report, we have used DSS Economic Assistance Regions in our analyses of geographic differences in population growth, since they are large enough to capture significant economic and demographic trends but small enough so that they capture the significant diversity in LTC services and utilization across the State.[4] Exhibits 2 through 8 show projections of the numbers of elders (over age 65) in each of the eight DSS Economic Assistance Regions for the years 2010, 2015, 2020, 2025, 2030, and 2035, respectively. Projections are aggregated from county-level estimates produced by the South Dakota Data Center and the U.S. Census, and reflect projected in-migration, out-migration, and death rates for the population.

Local LTC services will be stressed both by growth in the numbers of seniors as well as by high rates of growth in demand for care: Exhibit 9 highlights counties where the population of seniors is expected to more than double between 2010 and 2035. Exhibits 10 through 16 describe growth in the numbers of disabled elders from 2010 to 2035, again by region. Exhibit 17 highlights counties where the population of disabled elders is expected to more than double between 2010 and 2035. Finally, Exhibits 18 and 19 summarize the population projections by Economic Assistance Region in tabular form.

Overall, the geographic variation in growth rates across Economic Assistance Regions in this updated report is similar to that seen in the prior report. In particular:

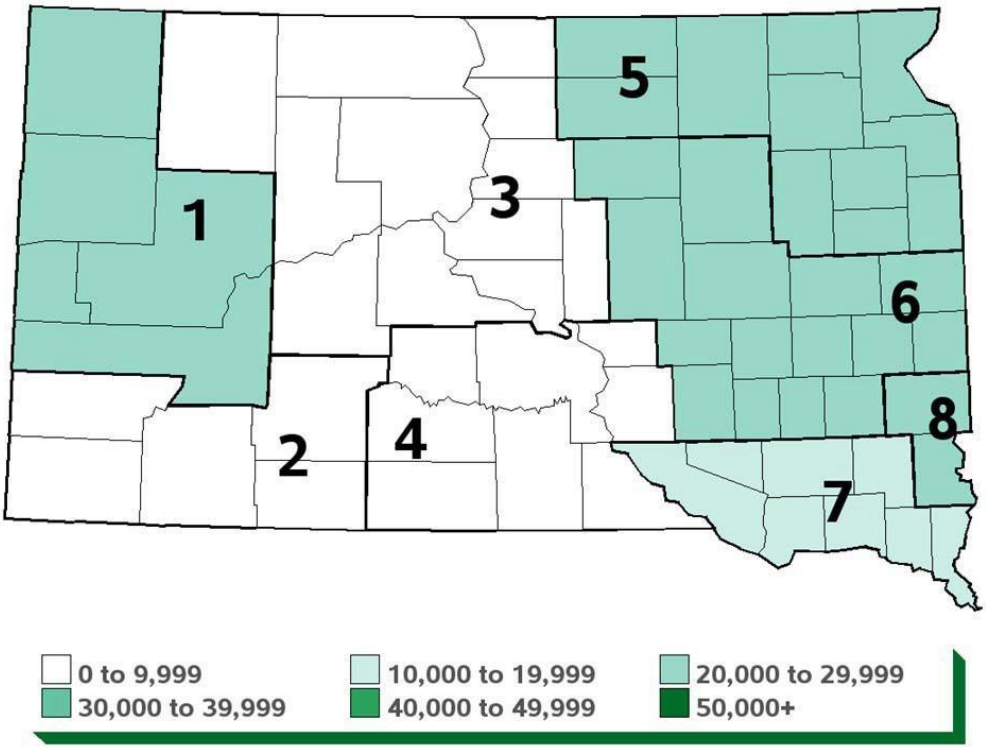
- Growth rates for the elderly and disabled elderly population are again projected to be greater in West River (Regions 1 and 2) than East River (Regions 5 through 8).
- The regions including the Sioux Falls metropolitan area (Region 8) and the Rapid City/Northwest counties (Region 1) continue to exhibit the fastest rates of anticipated growth, as well as the largest growth in the overall numbers of elders. However, as with total projected Statewide growth, overall growth rates from 2010 to 2035 are now projected to be more moderate previously projected for Regions 1 and 8 for the years 2000 to 2025 in the prior report.
    - Specifically, the Region 1 elderly population was previously projected to grow by 250 percent from 2000 to 2025; updated projections now indicate a 110 percent increase from 2010 to 2035.

[4] Note that since the previous report, Turner County has moved from Economic Assistance Region 8 to Economic Assistance Region 7. This change does not substantively influence our findings, but should be noted when comparing figures for these two Economic Assistance Regions across the earlier 2007 report and these updated analyses.

- For Region 8, the elderly population was projected to increase 235 percent from 2000 to 2025, as compared to a 170 percent increase from 2010 to 2035 in the updated projections.

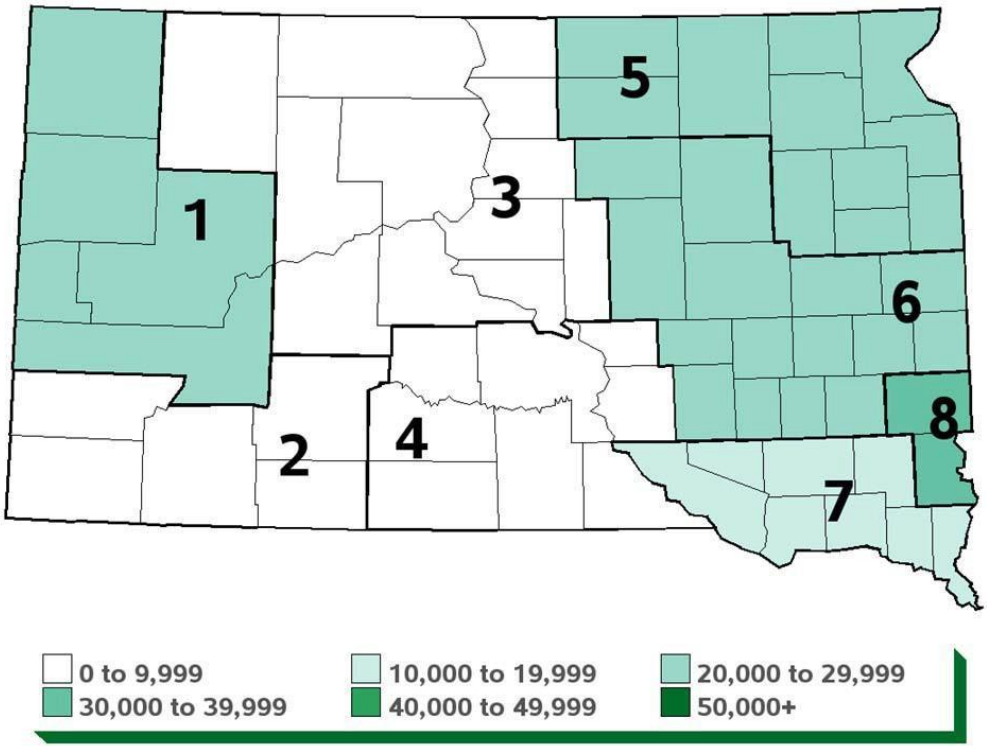
- Growth in both Region 1 and Region 8 continues to be fueled by the migration of seniors from frontier areas towards urban areas and medical centers.
- In 2000, there were 22 counties where the elderly population exceeded 20 percent of total residents in the county. By 2010, there were 42 counties where the elderly population exceeded 20 percent of total residents.
- By 2035, in all but 10 South Dakota counties elders will make up over 20 percent of the population. In 27 counties, elders will be over 40 percent of the local population. Even in the growing population centers, around Sioux Falls and Rapid City, elders will make up 29-30 percent of residents.

Exhibit 2. Number of Elderly Residents 65+, South Dakota, 2010



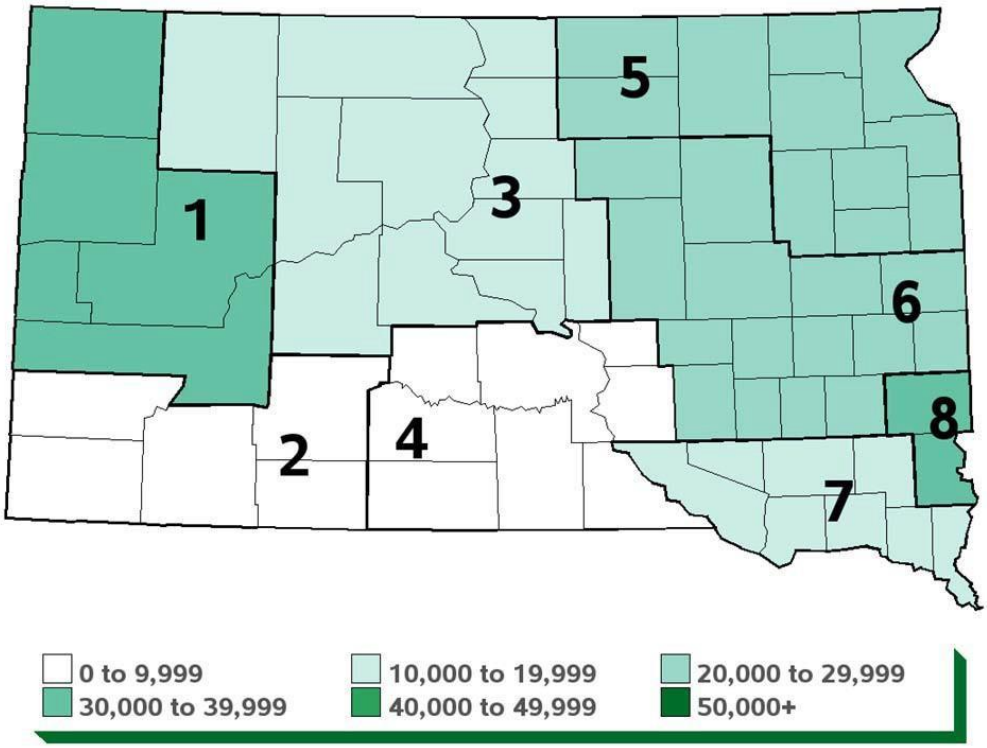
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data.

Exhibit 3. Number of Elderly Residents 65+, South Dakota, 2015



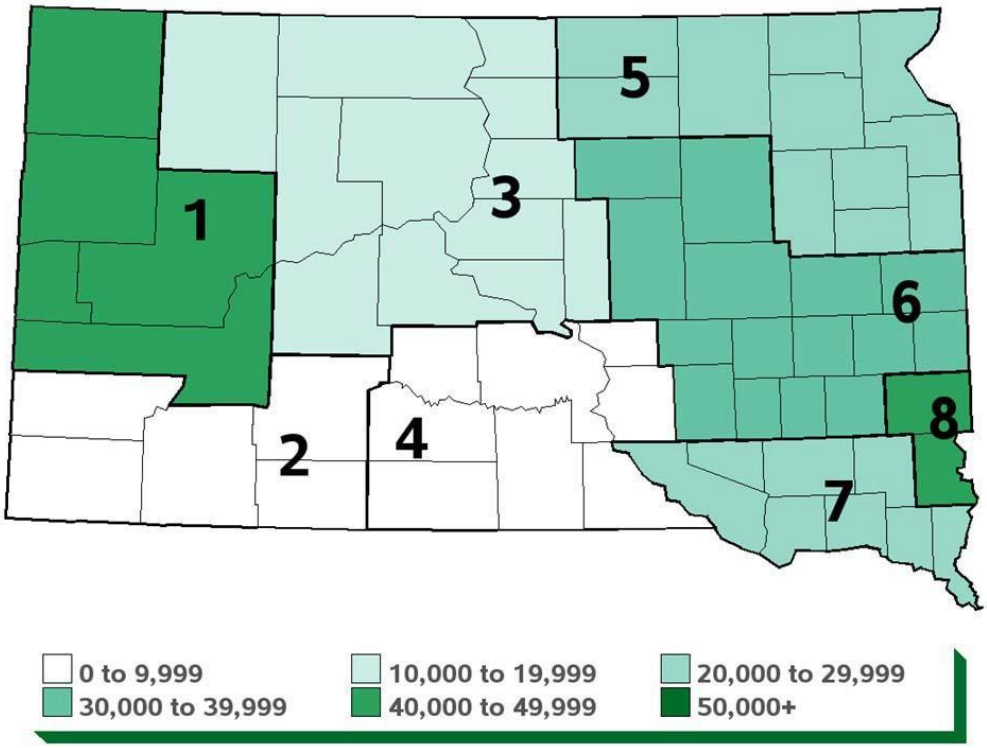
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data.

Exhibit 4. Number of Elderly Residents 65+, South Dakota, 2020



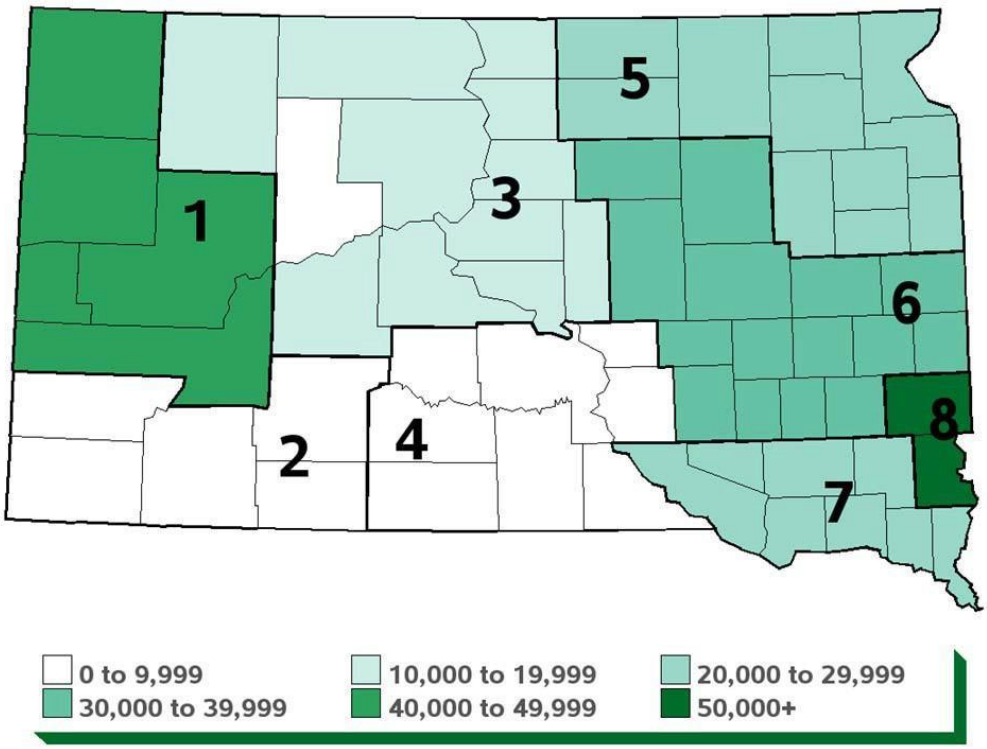
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data.

Exhibit 5. Number of Elderly Residents 65+, South Dakota, 2025



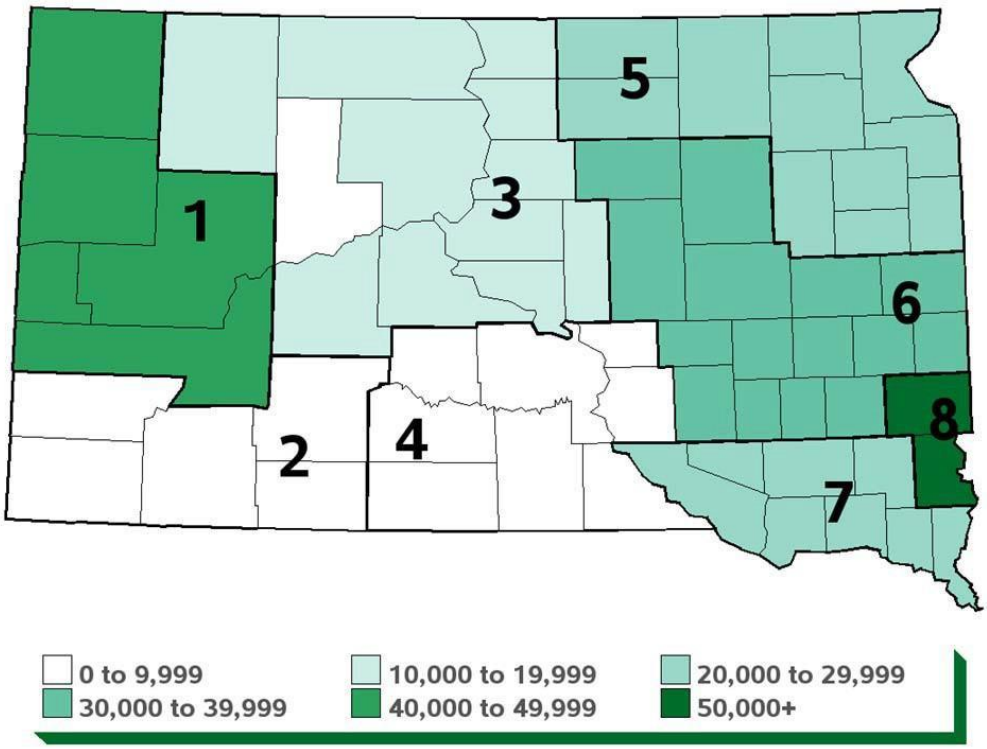
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data.

Exhibit 6. Number of Elderly Residents 65+, South Dakota, 2030



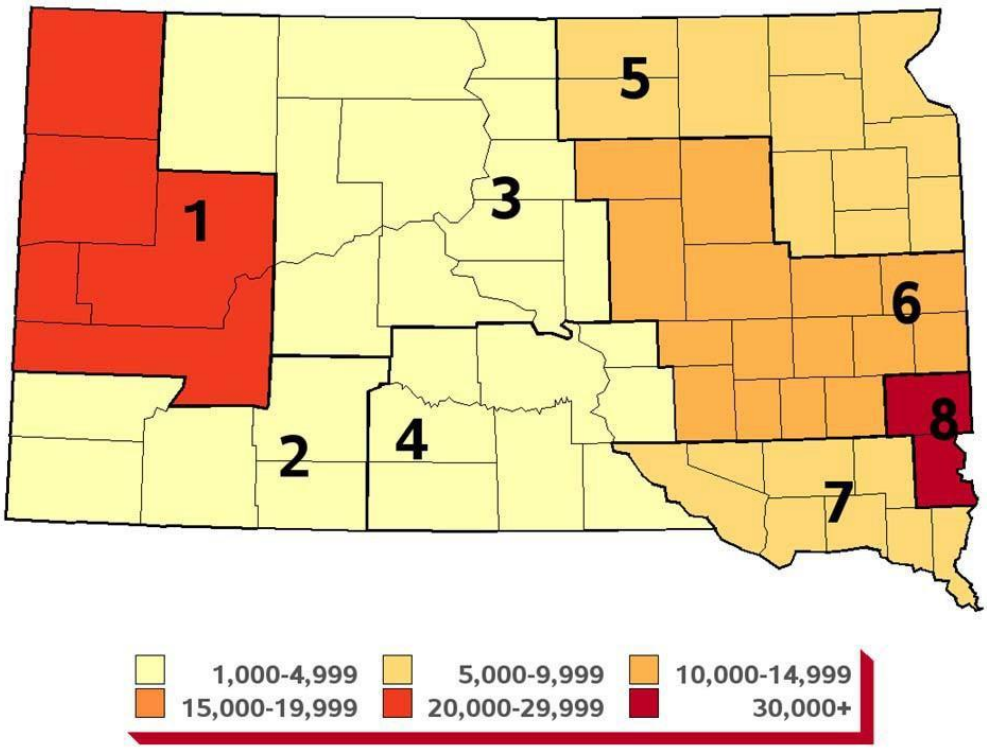
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data.

Exhibit 7. Number of Elderly Residents 65+, South Dakota, 2035



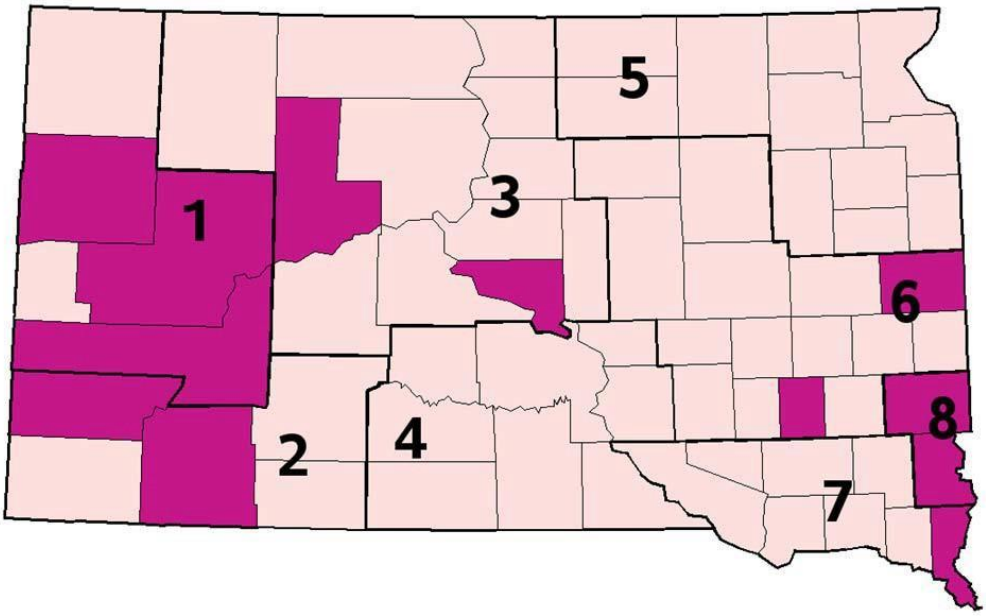
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data.

Exhibit 8. Increase in Number of Elderly 65+ Residents, South Dakota, 2010 – 2035



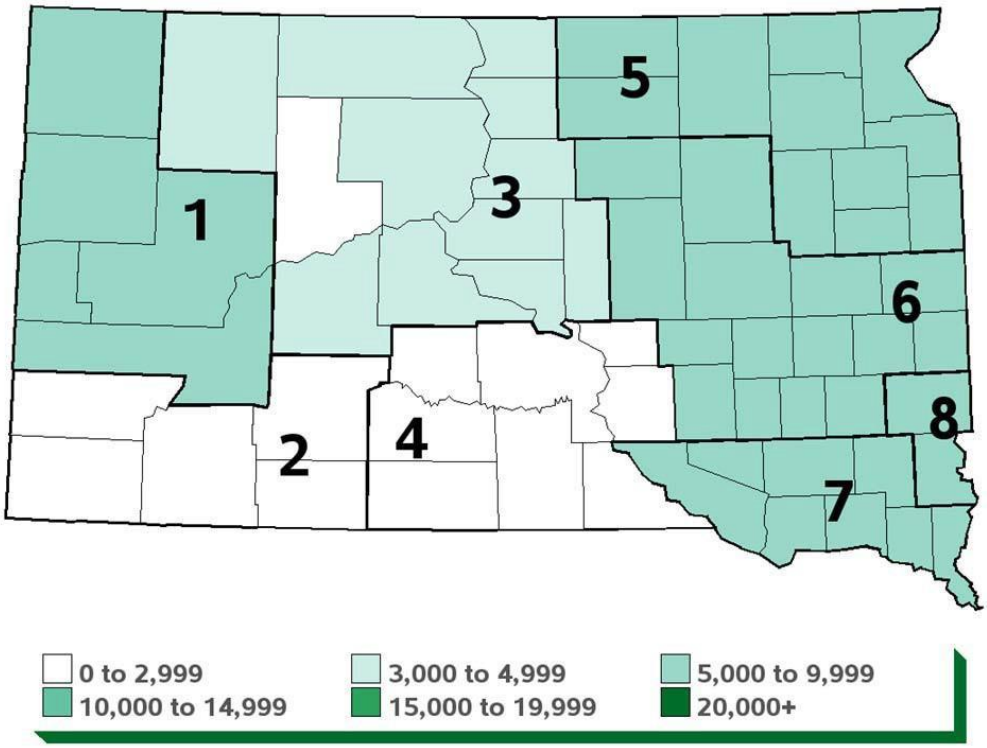
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data.

Exhibit 9. South Dakota Counties Where Elderly Population Is Expected to Double from 2010 to 2035 (in Dark Pink)



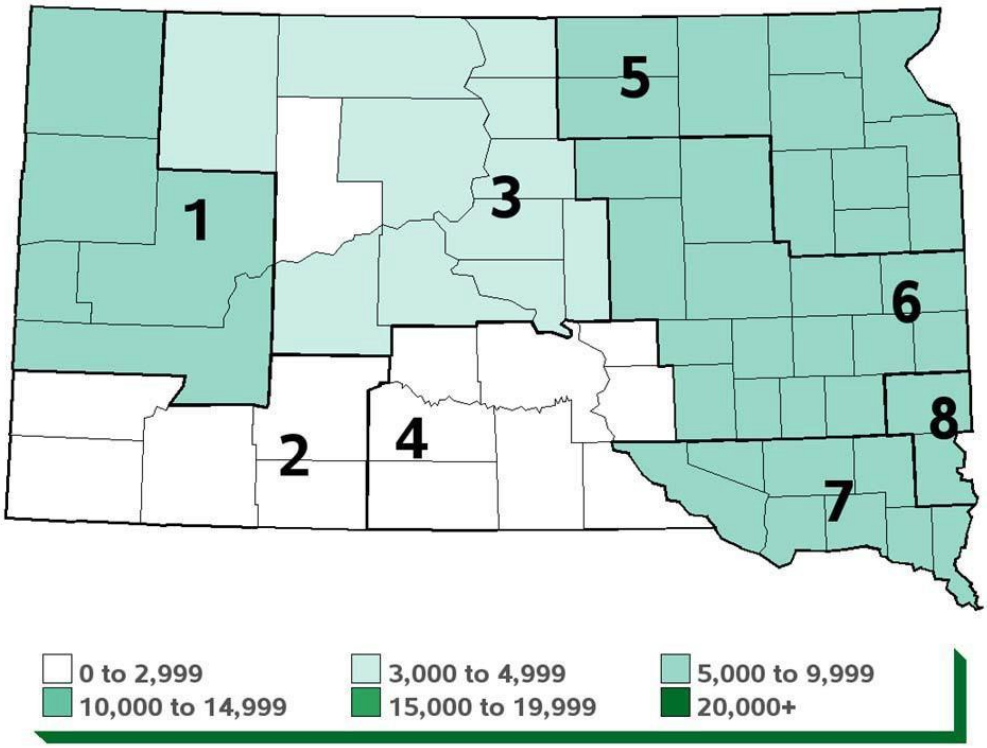
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data.

Exhibit 10. Number of Disabled Elderly Residents 65+, South Dakota, 2010



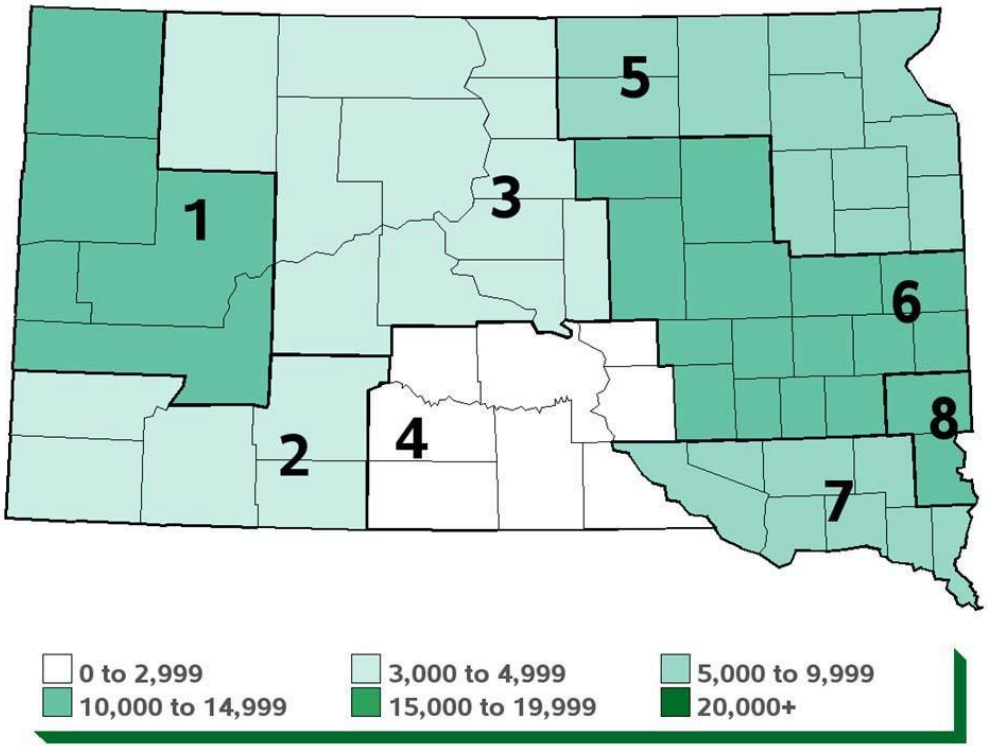
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, and American Community Survey data.

Exhibit 11. Number of Disabled Elderly Residents 65+, South Dakota, 2015



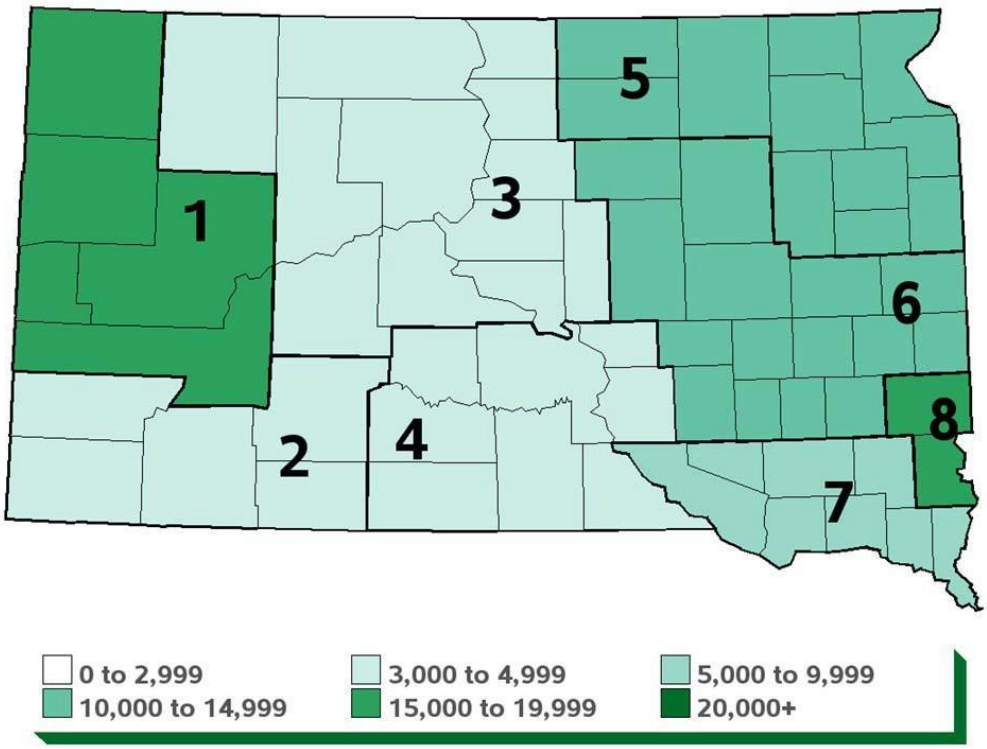
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, and American Community Survey data.

Exhibit 12. Number of Disabled Elderly Residents 65+, South Dakota, 2020



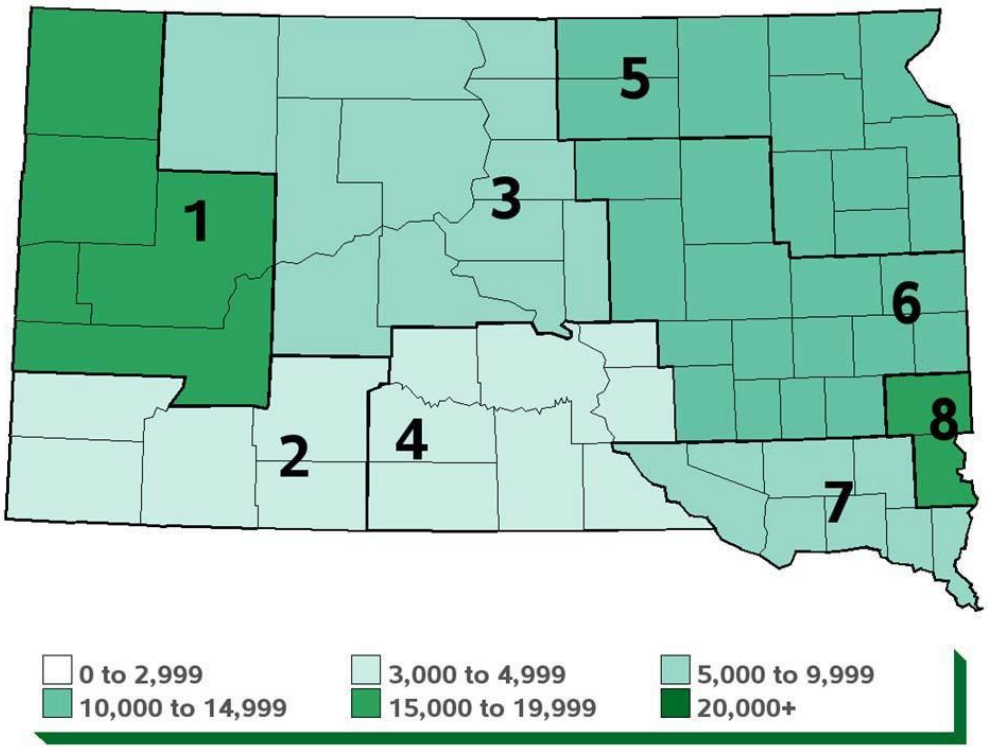
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, and American Community Survey data.

Exhibit 13. Number of Disabled Elderly Residents 65+, South Dakota, 2025



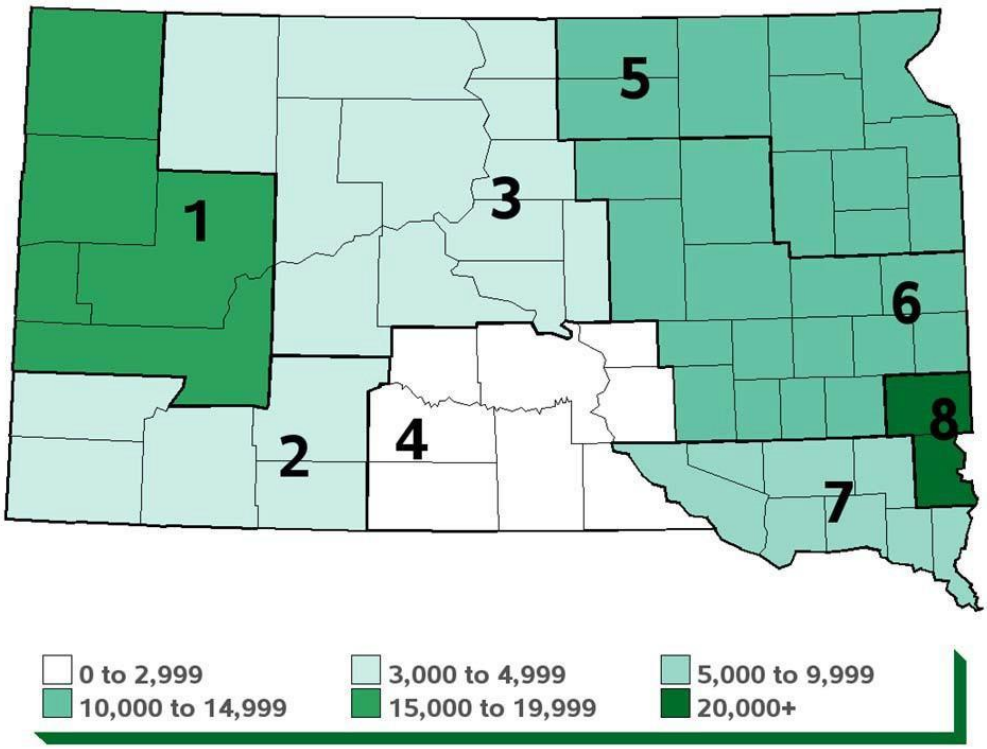
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, and American Community Survey data.

Exhibit 14. Number of Disabled Elderly Residents 65+, South Dakota, 2030



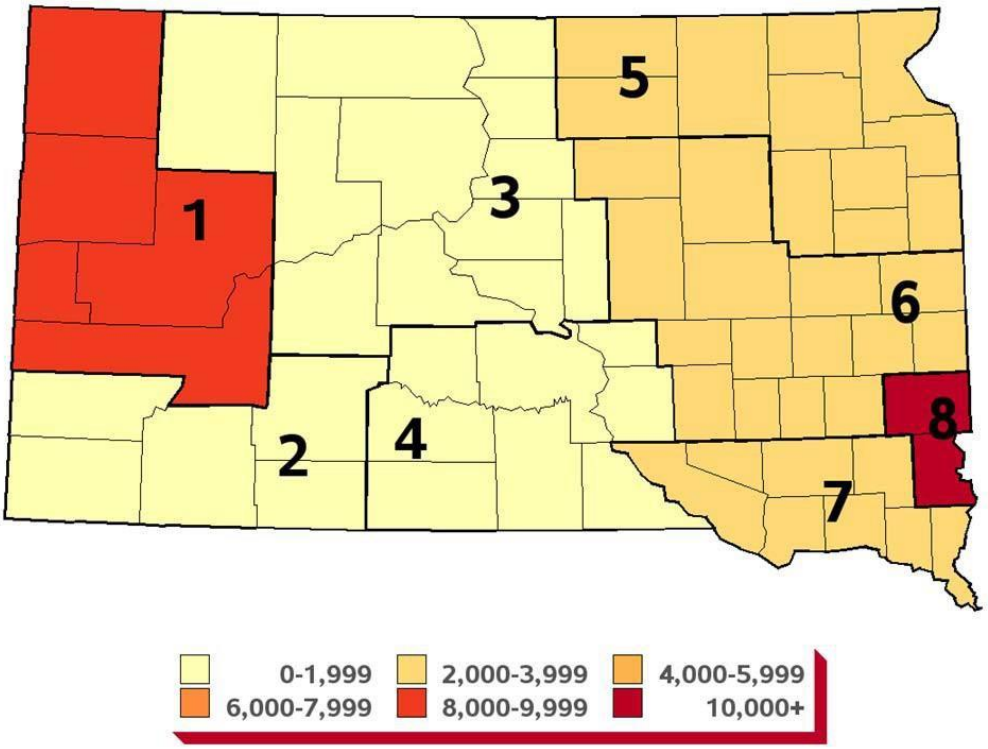
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, and American Community Survey data.

Exhibit 15. Number of Disabled Elderly Residents 65+, South Dakota, 2035



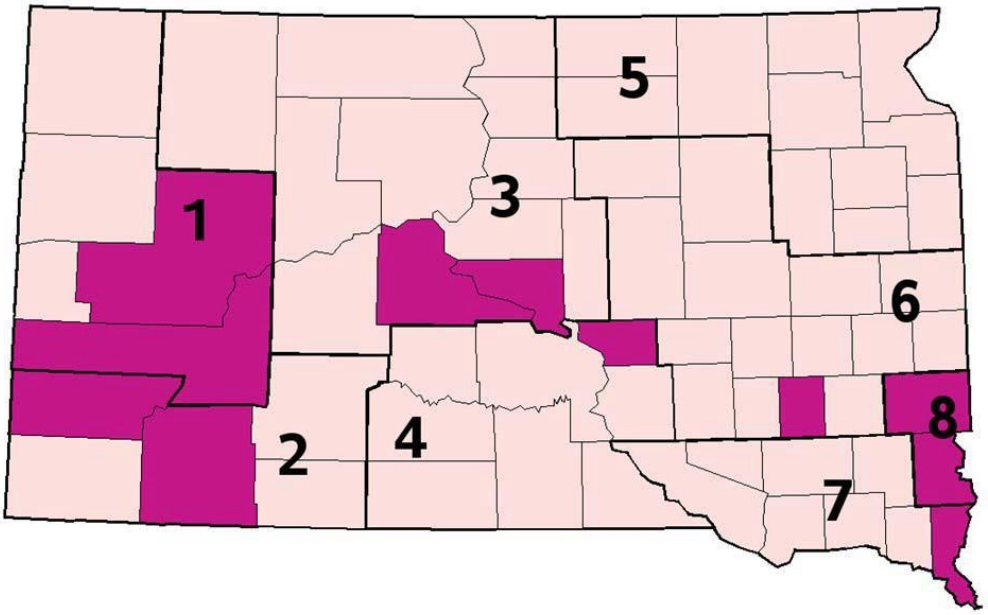
Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, and American Community Survey data.

Exhibit 16. Increase in Number of Disabled Elderly 65+ Residents, South Dakota, 2010 – 2035



Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, and American Community Survey data.

Exhibit 17. South Dakota Counties where the Elderly Disabled Population is expected to double from 2010 to 2035 (in Dark Pink)



Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, and American Community Survey data.

Exhibit 18. Projections of Elderly 65+ Population, South Dakota, by Economic Assistance Region, 2010-2035

EAR	2010	2015	2020	2025	2030	2035
1	23,156	28,770	35,615	42,176	46,797	48,258
2	5,173	6,474	7,805	8,870	9,500	9,566
3	8,310	9,419	10,595	11,716	12,198	11,792
4	5,071	5,569	6,116	6,591	6,642	6,179
5	20,838	23,130	25,908	28,518	30,164	29,634
6	21,096	23,450	26,919	30,193	32,022	31,620
7	15,301	17,222	19,586	22,010	23,645	23,950
8	23,917	30,541	38,981	48,467	57,917	64,746
Total	122,862	144,575	171,527	198,542	218,886	225,744

Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data.

Exhibit 19. Projections of Disabled Elderly 65+ Population, South Dakota, by Economic Assistance Region, 2010-2035

EAR	2010	2015	2020	2025	2030	2035
1	9,155	9,938	12,739	15,409	18,298	18,563
2	2,065	2,335	3,005	3,357	3,879	3,763
3	3,404	3,392	4,111	4,439	5,094	4,809
4	2,511	2,472	2,845	3,124	3,386	2,999
5	8,508	7,898	9,725	10,353	12,061	10,963
6	8,633	8,070	10,055	10,747	12,631	11,629
7	6,307	5,666	7,160	7,670	9,253	8,531
8	9,187	9,358	12,571	16,021	20,255	21,556
Total	49,770	49,129	62,211	71,120	84,857	82,812

Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, and American Community Survey data.

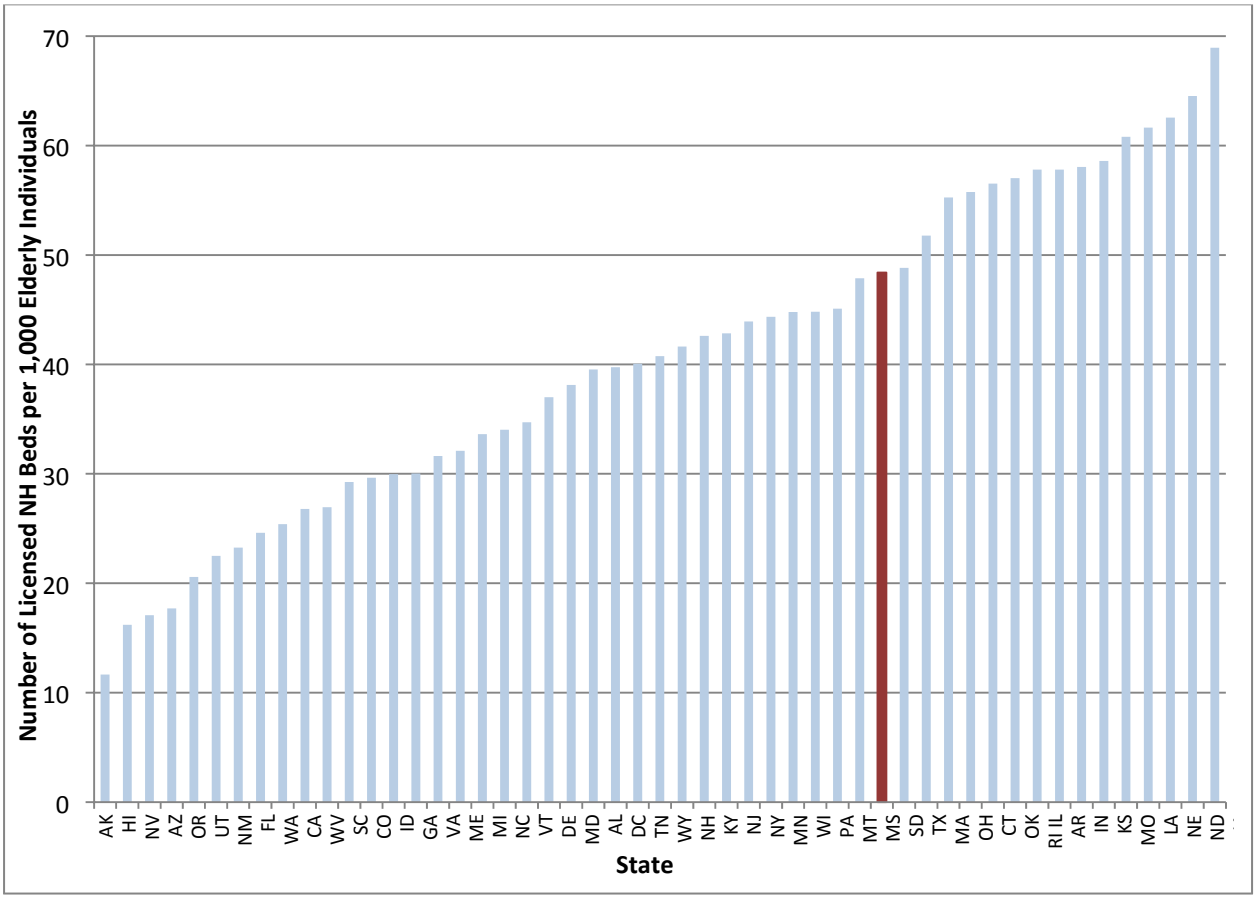
4. Service Delivery Challenges

This section provides evidence on the distribution of existing LTC services across South Dakota, and considers that service distribution in relation to projected future demands on the LTC system. As in the prior report, we discuss services at the State level and also examine geographic variation, making use of the DSS Economic Assistance Regions for most analyses. In particular, we focus on variation in service availability, gaps in coverage and mismatches between where services are and where the growth in the population of elders is the greatest.

4.1 Nursing Homes

Nursing home capacity and utilization rates have continued to drop both in South Dakota and nationwide since the release of the prior final report. In 2006, the most recent data available for the prior report, South Dakota ranked tenth in the nation in terms of nursing home capacity, with 61 licensed beds per 1,000 elders. By 2011, that number had dropped substantially to 48 licensed beds per 1,000 elders, sixteenth nationwide (Exhibit 20). Though South Dakota's capacity remains higher than national averages, the drop between 2006 and 2011 indicates that the gap is shrinking.

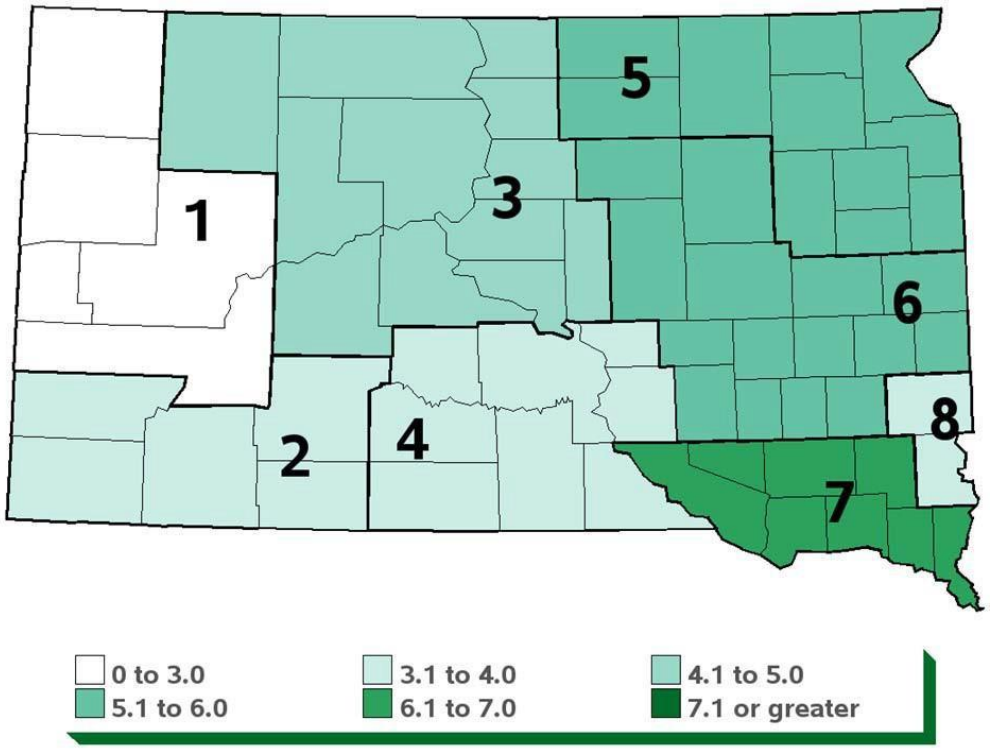
Exhibit 20. National Comparison of State Nursing Home Capacity, 2011



Source: Abt Associates' analysis of Henry J. Kaiser Family Foundation's Nursing Home Beds data and American Community Survey data. South Dakota utilization rates appear in red.

The number of licensed nursing facility beds in use per 100 elderly individuals has declined slightly from 2003-2005 levels, with a minimum of 2.6 beds in use per 100 elderly individuals in Economic Assistance Region 1 and a maximum of 6.4 beds in use per 100 elderly individuals in Economic Assistance Region 7. As in the prior report, utilization rates are substantially higher in the East River regions (5 through 8) than in the West River regions (1 and 2).

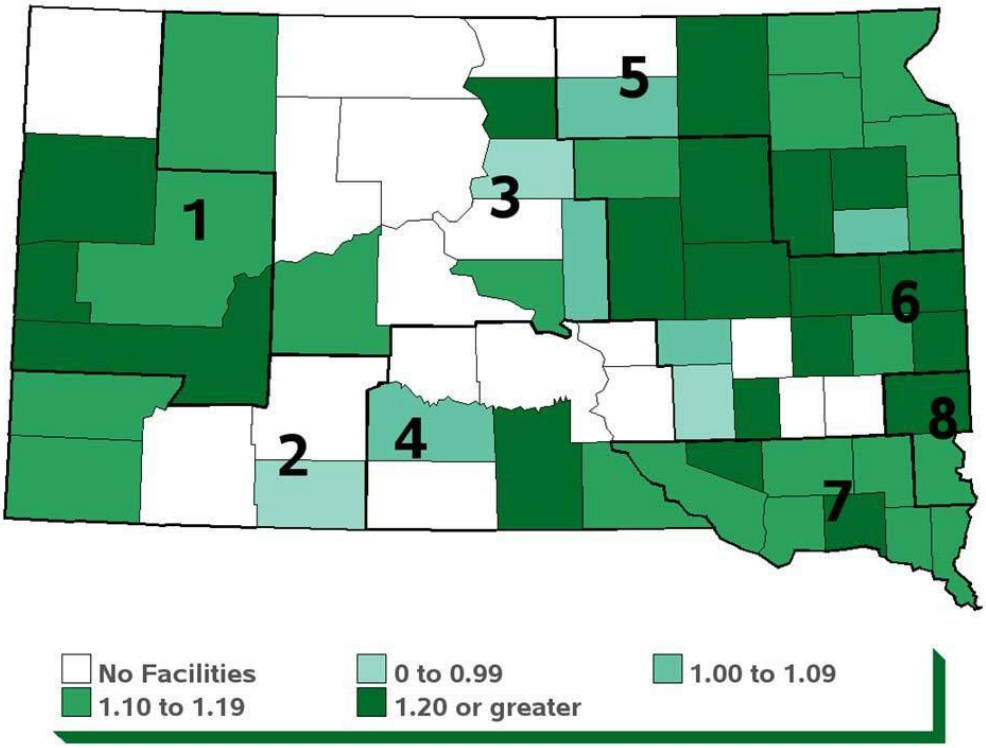
Exhibit 21. Number of Licensed Beds in Use per 100 Elderly Individuals, South Dakota, 2014



Source: Abt Associates' analysis of South Dakota's Nursing Facilities Data and Nursing Home Compare data.

Medicaid case mix weights reflect the severity or complexity of care needs among nursing home residents. In 2013, case mix weights have risen somewhat from the 2005 values as documented in our prior report; however, the geographic distribution remains similar, with the highest case mix weights in the same counties (Exhibit 22). This suggests that constraints on service delivery remain in the same geographic regions as in the prior report; it could additionally suggest that less-impaired individuals are differentially moving to less intensive LTC settings, such as assisted living.

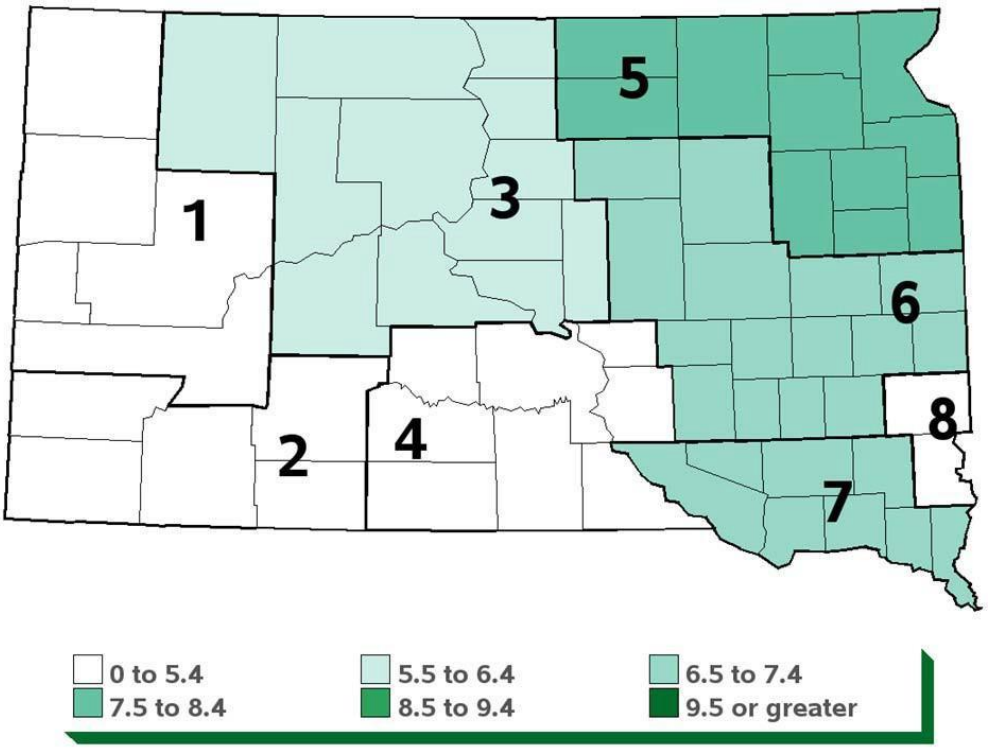
Exhibit 22. Nursing Facility Medicaid Case Mix Variation by County, South Dakota, 2013



Source: Abt Associates' analysis of South Dakota's Nursing Facilities Case Mix Data.

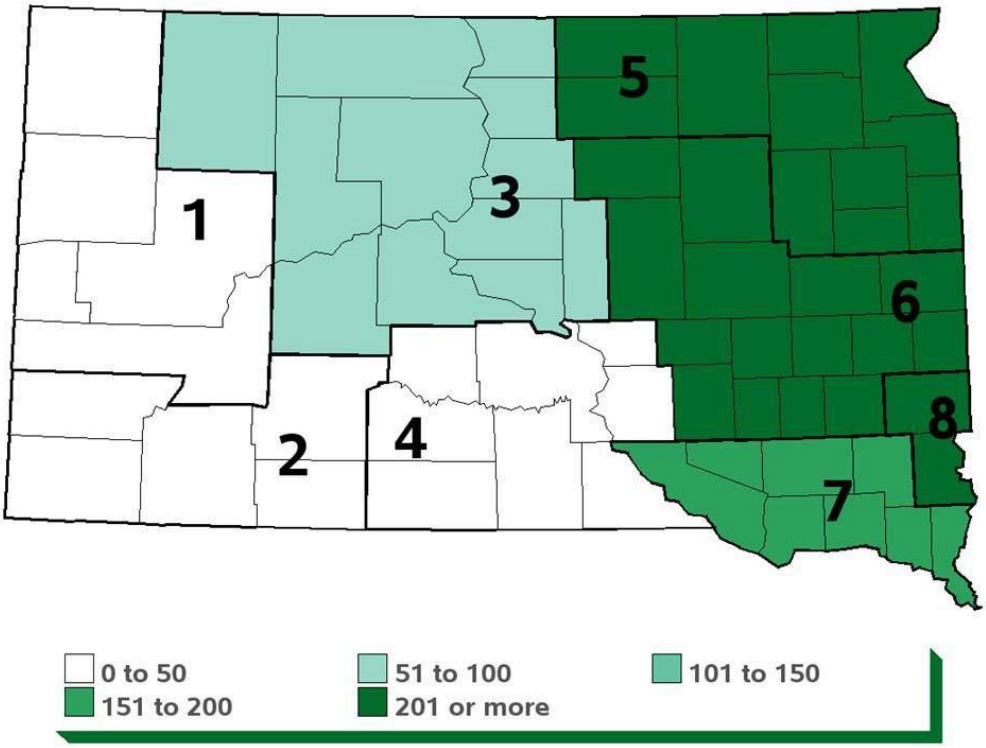
Although the passage of SB196 in 2012 has facilitated some geographic shifts in moratorium beds, the overall distribution of moratorium beds per 100 elderly residents (Exhibit 23) has remained similar since the prior report. It is therefore unsurprising that the East River region of the State (Regions 5 through 8) continues to have the greatest moratorium bed capacity and the greatest difference between moratorium bed capacity and the number of licensed beds that have recently been in use (Exhibit 24), with lower capacity and a smaller difference in West River. As growth of the elderly population is still projected to be largest in urban areas around Sioux Falls and Rapid City, additional shifting of beds may be required to appropriately accommodate the growing number of seniors.

Exhibit 23. Number of Nursing Facility Moratorium Beds per 100 Elderly Individuals, South Dakota, 2014



Source: Abt Associates' analysis of South Dakota's Nursing Facilities Data, South Dakota Department of Social Services' Occupancy Report, and Nursing Home Compare data.

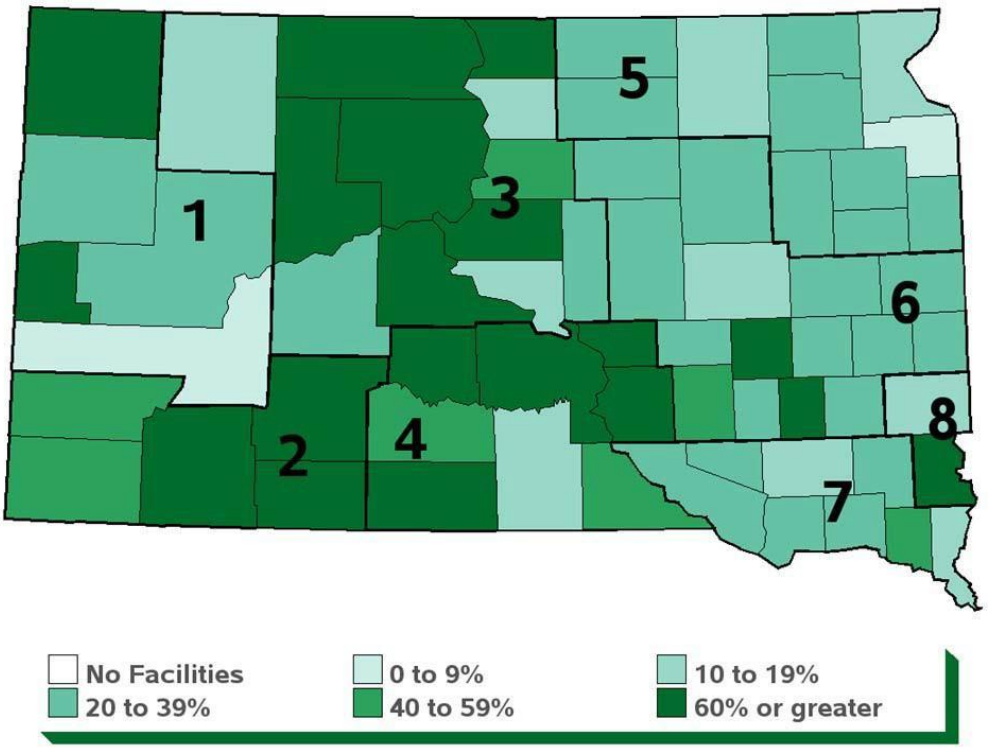
Exhibit 24. Difference between Moratorium and Maximum Licensed Nursing Facility Beds, South Dakota, 2014



Source: Abt Associates' analysis of South Dakota's Nursing Facilities Data, South Dakota Department of Social Services' Occupancy Report, and Nursing Home Compare data.

Finally, in general, nursing home travel patterns in 2012 (Exhibit 25) remained similar to patterns in the 2007 report, with relatively few South Dakotans leaving their home counties overall. Those that did leave their counties tended to reside in higher-occupancy counties and/or counties with older nursing homes, indicating a continued preference for newer facilities.

Exhibit 25. Nursing Home Travel Patterns, South Dakota, 2012



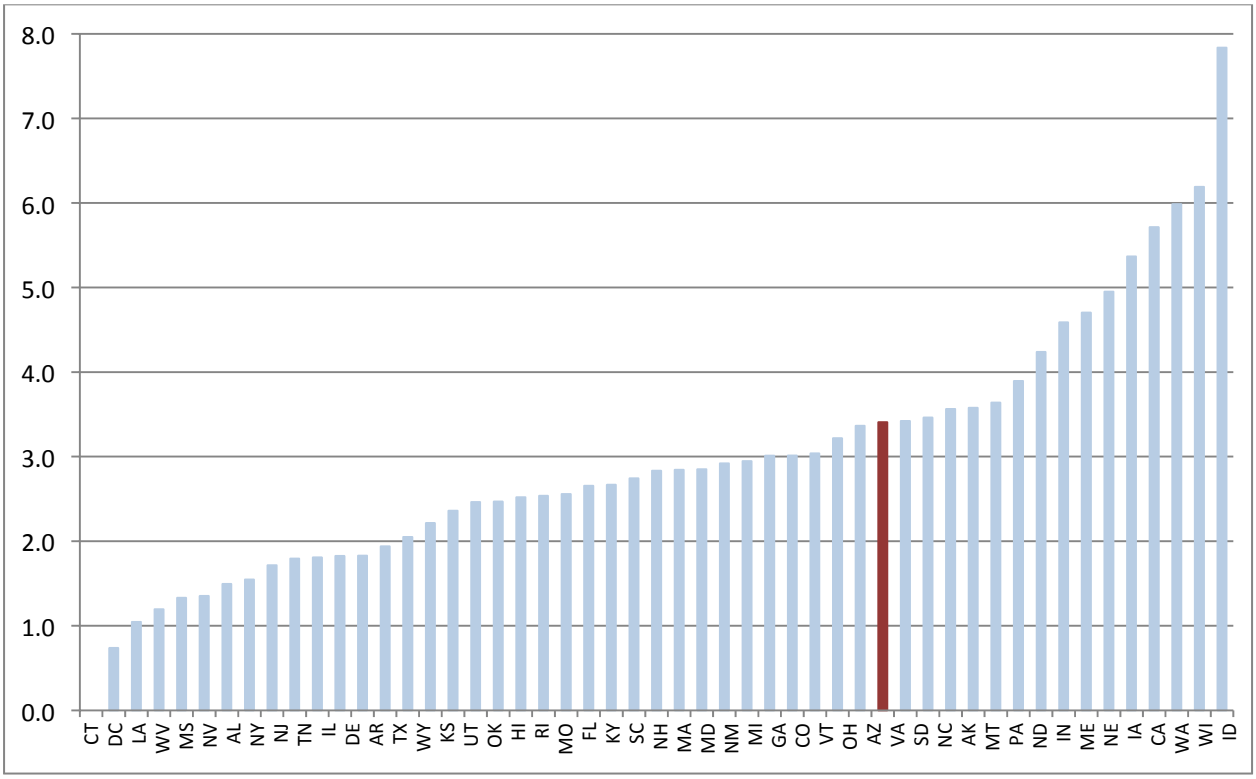
Source: Abt Associates' analysis of South Dakota's Nursing Facility Patient Origin Data.

4.2 Assisted Living

Relative to other states, South Dakota ranked 16th for available assisted living beds in 2010, at 3.4 available beds per 100 elderly individuals (Exhibit 26). This represents a slight increase in the number of available beds from roughly 3 per 100 elderly individuals in 2004, which placed South Dakota 15th among the states at that time.

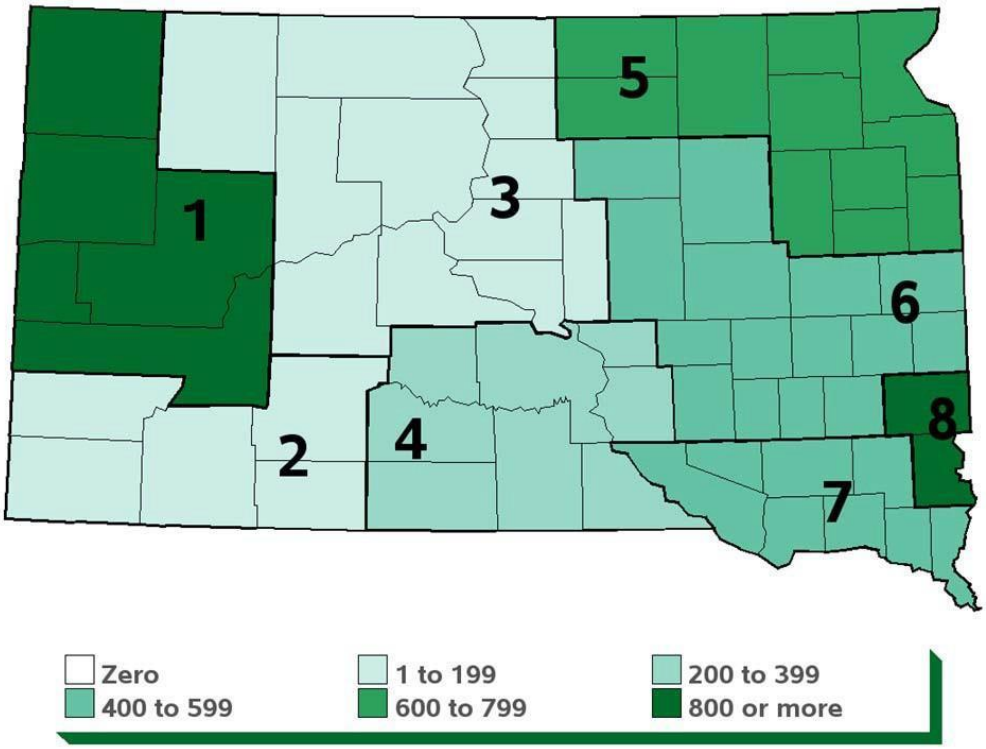
All regions of the State displayed growth in the total number of licensed assisted living beds since the last report, but substantial geographic variation remains (Exhibits 27 and 28).

Exhibit 26. National Comparison of Available Assisted Living Beds per 100 Elderly Individuals by State, 2010



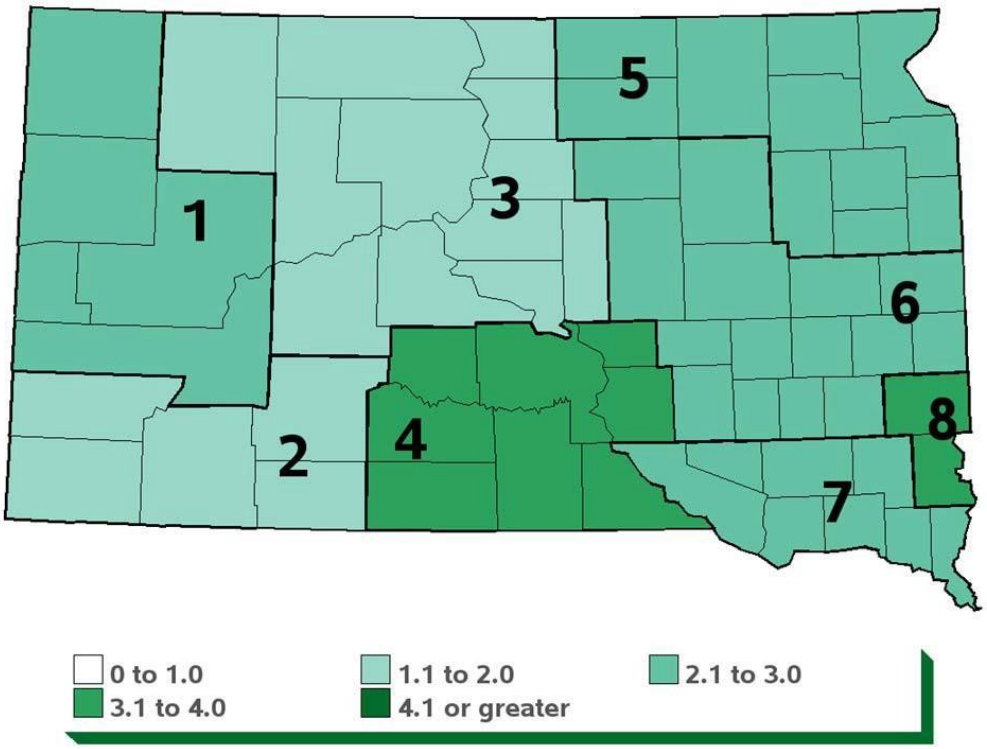
Source: Abt Associates' analysis of AARP's Assisted Living and Residential Care in the United States data, 2010. South Dakota beds per 100 elderly individuals shown in red.

Exhibit 27. Number of Licensed Assisted Living Beds, South Dakota, 2014



Source: Abt Associates' analysis of South Dakota's Assisted Living Data.

Exhibit 28. Number of Licensed Assisted Living Beds per 100 Elderly Individuals, South Dakota, 2014

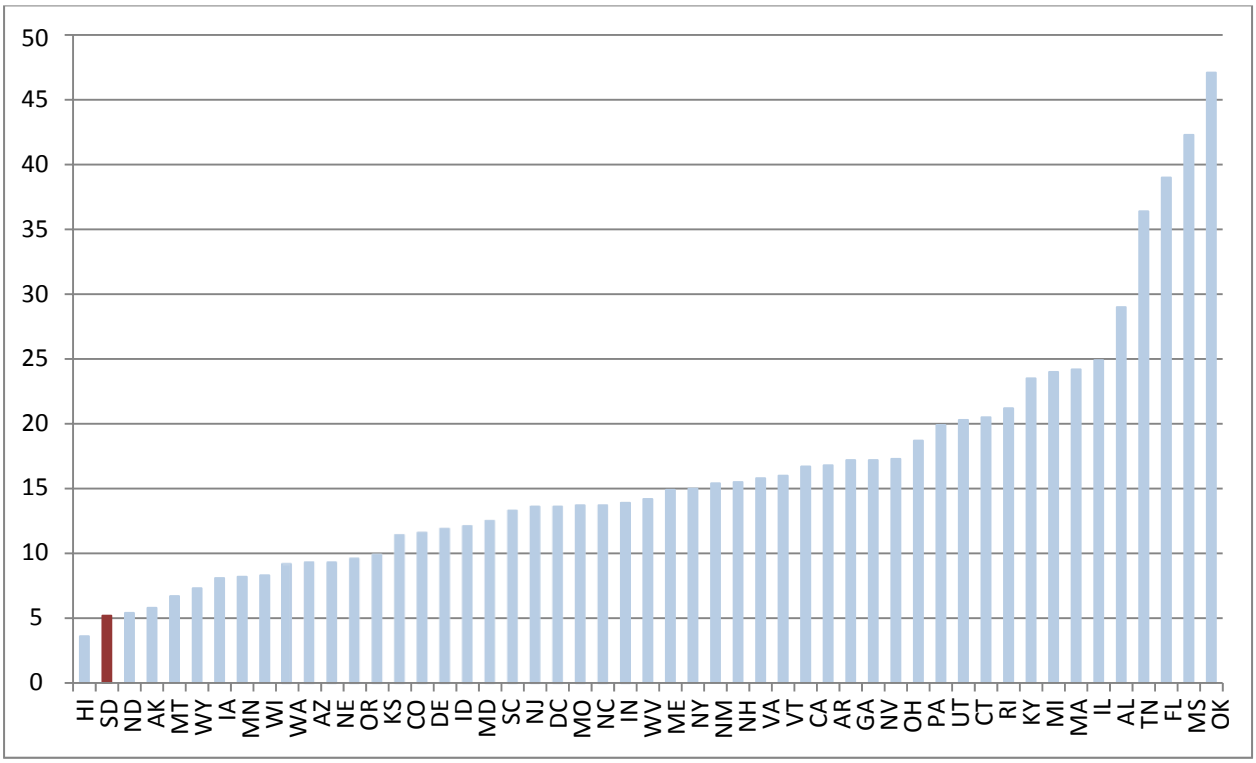


Source: Abt Associates' analysis of South Dakota's Assisted Living Data, and South Dakota Data Center's Population Projections data.

4.3 Home Health Care

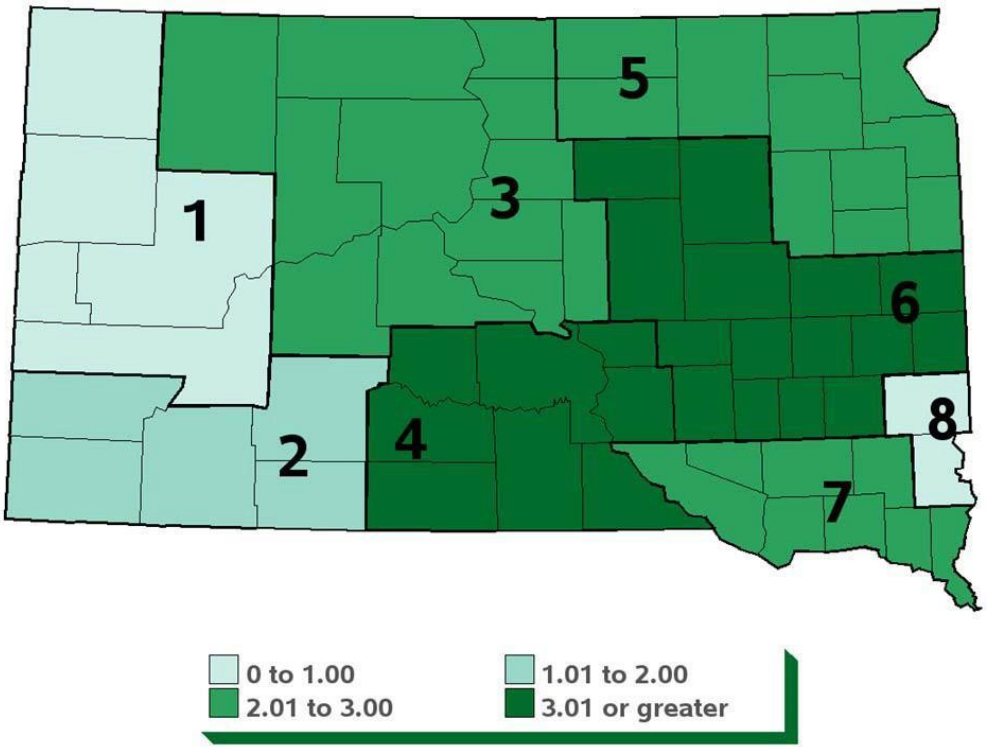
South Dakota continues to have the 2nd fewest Medicare skilled home health episodes of the 50 states, with just over 5 episodes per 100 elderly individuals, compared to a national average of 16 (Exhibit 29). There is little evidence of a shift in geographic patterns in Medicaid- and Medicare-certified home health agencies (Exhibit 30) or visits (Exhibit 31) since the prior report.

Exhibit 29. Number of Medicare Skilled Home Health Episodes per 100 Elderly Individuals by State, 2012



Source: Abt Associates' analysis of Center for Medicare and Medicaid Service's CCW Administrative Claims summary data as provided by the Centers for Disease Control and Prevention Health Indicators Warehouse (healthindicators.gov). South Dakota episodes per 100 elderly individuals shown in red.

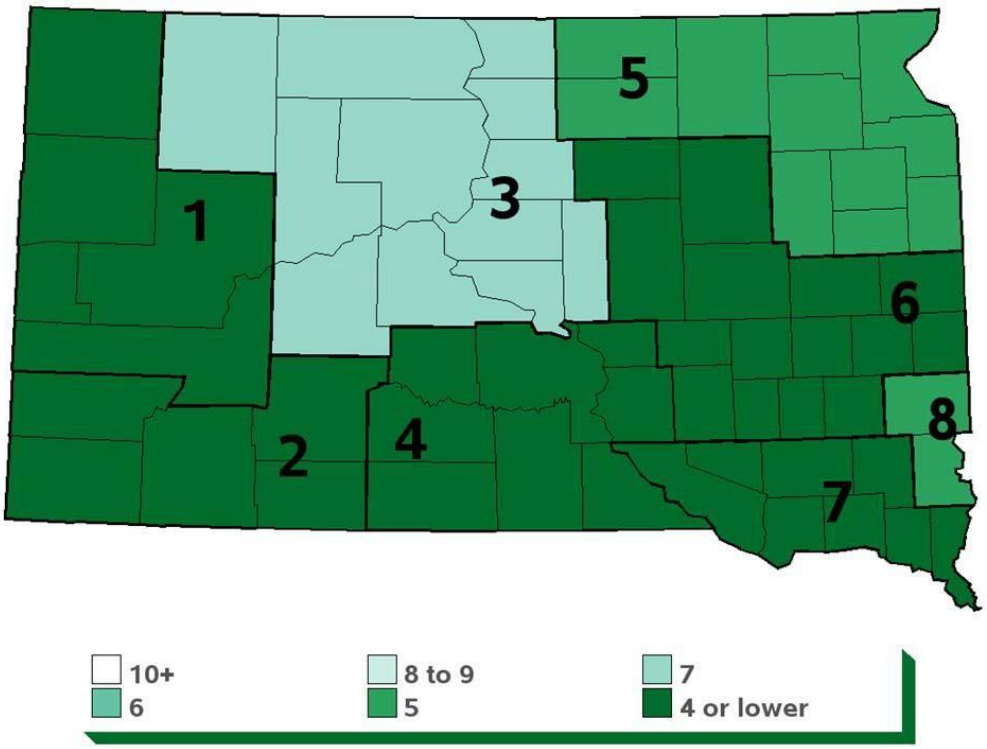
Exhibit 30. Number of Medicaid- and Medicare-Certified Home Health Agencies per 1,000 Elderly Individuals, South Dakota, 2014



Source: Abt Associates' analysis of Home Health Compare data.

Notes: The map shows the number of Medicaid- and Medicare-Certified Home Health Agencies that serve each county. Many Home Health Agencies serve more than one county; therefore, adding up agencies serving each county will not result in the total number of agencies in South Dakota. This map also includes agencies that are headquartered outside the State of South Dakota, but are listed as serving certain counties in South Dakota.

Exhibit 31. Number of Medicaid and Medicare Home Health Episodes per 100 Medicare Beneficiaries, South Dakota, 2014



Source: Abt Associates' analysis of Center for Medicare and Medicaid Service's CCW Administrative Claims summary data as provided by the Centers for Disease Control and Prevention Health Indicators Warehouse (healthindicators.gov).

4.4 Home and Community Based Services

Home and community based services are a critical support component to allow elders to remain in the community as long as possible. Since the prior report, we do not see evidence of perceptible shifts in availability of home and community based services in South Dakota: adult day facilities (Exhibit 32), senior centers (Exhibits 33 and 34), nutrition programs (Exhibit 35), homemaker services (Exhibit 36), and in-home service clients (Exhibit 37) all remain at similar, relatively low levels.

In short, across the State, and particularly in rural and frontier areas, there is limited availability of home and community based care. Clearly, a major barrier to providing community based care is the lack of a sufficiently sized community in many parts of the state. Briefly, in 2014:

- 43 counties have no adult day facilities with an established relationship with the State[5],
- 6 counties have 0 senior centers and 20 have just 1 senior center[6],
- 1 county has 0 nutrition programs and 25 have just 1 nutrition program[7], and
- Although every county in South Dakota is served by a DSS-affiliated homemaker agency, 36 counties have no DSS-affiliated homemaker agencies located in their borders.[8]

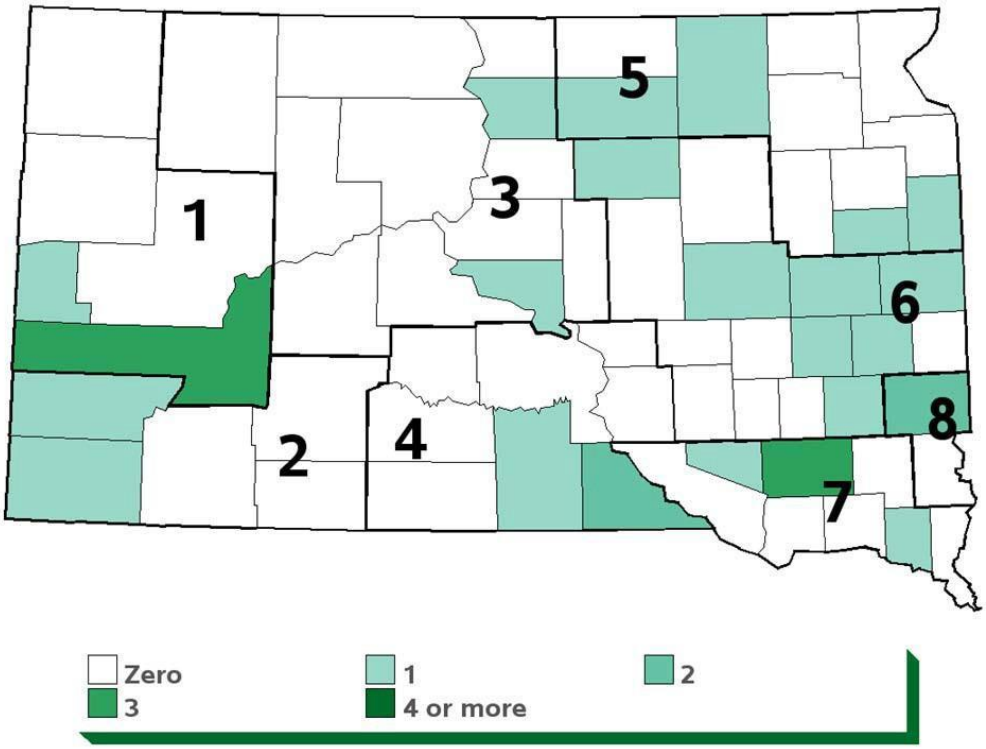
[5] Includes Adult Day Services Programs that have an established relationship with the State to provide adult day services; not an all-inclusive list.

[6] Includes centers appearing in listing of senior centers maintained by DSS; these senior centers do not receive state funding.

[7] Senior nutrition programs funded by Title III-C and/or Title VI (Older Americans Act direct funding to the tribes).

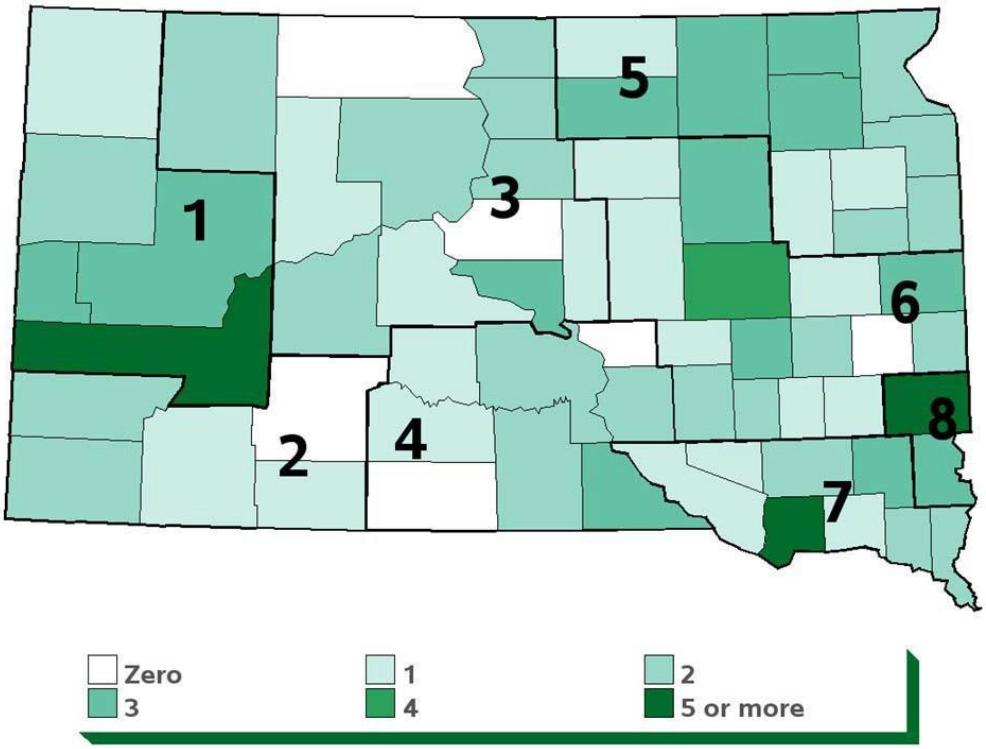
[8] Includes only homemaker agencies with existing relationship with DSS.

Exhibit 32. Number of Adult Day Facilities by County, South Dakota, 2014



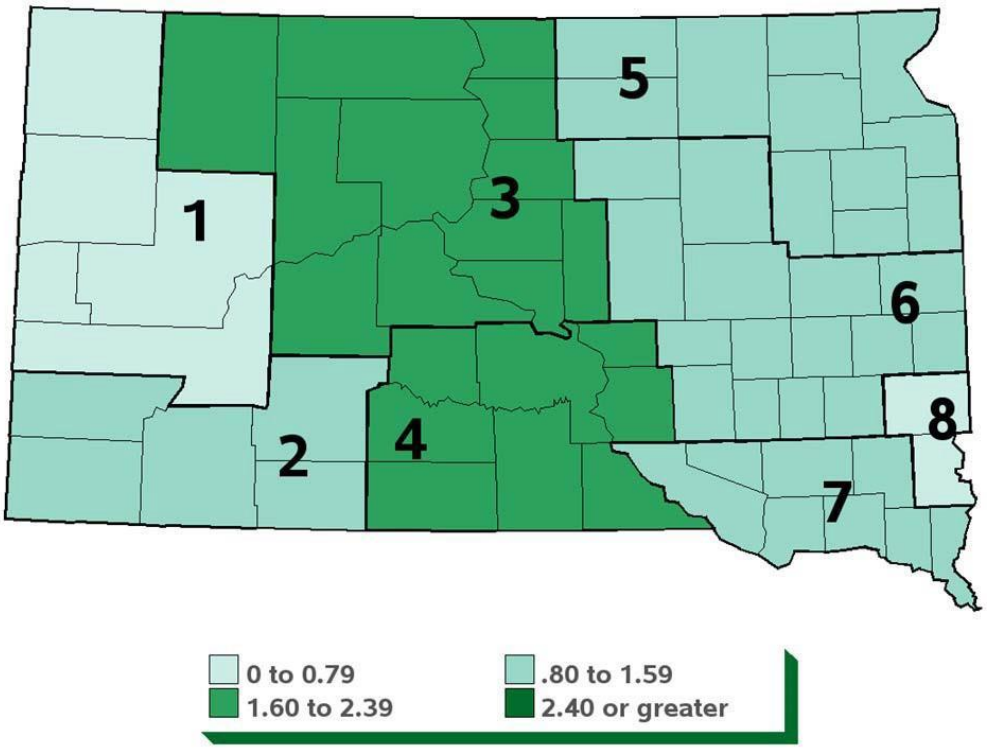
Source: Abt Associates' analysis of South Dakota's Adult Day Services Listing; includes Adult Day Services Programs that have an established relationship with the State to provide adult day services, and is not an all-inclusive list.

Exhibit 33. Number of Senior Citizens Centers by County, South Dakota, 2014



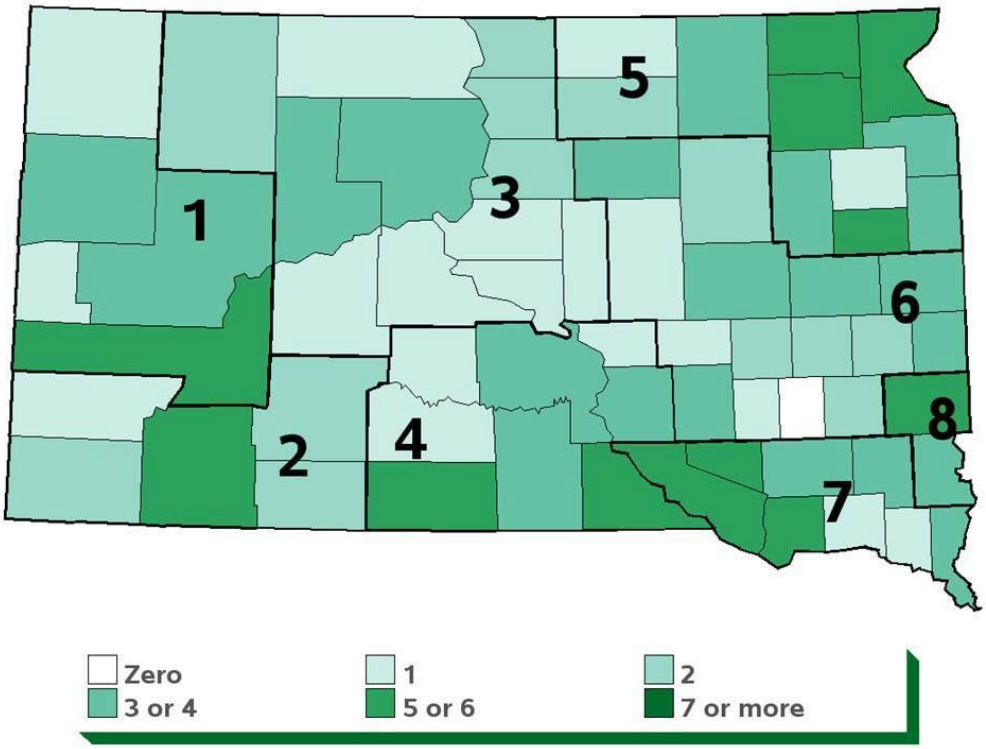
Source: Abt Associates' analysis of South Dakota's List of Senior Citizens Centers, 4/30/2014; listing maintained by DSS, but Senior Centers do not receive state funding.

Exhibit 34. Number of Senior Citizens Centers per 1,000 Elderly Individuals, South Dakota, 2014



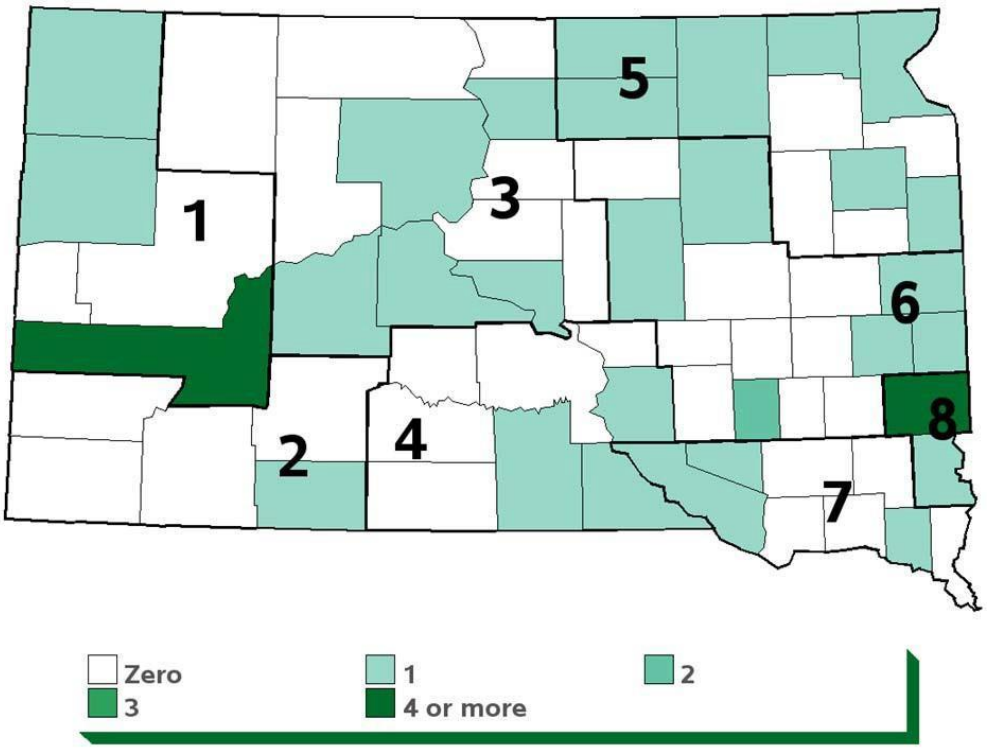
Source: Abt Associates' analysis of South Dakota's List of Senior Citizens Centers, 4/30/2014 and South Dakota Data Center's Population Projections data; listing maintained by DSS, but Senior Centers do not receive state funding.

Exhibit 35. Number of Nutrition Projects Serving Each County, South Dakota, 2014



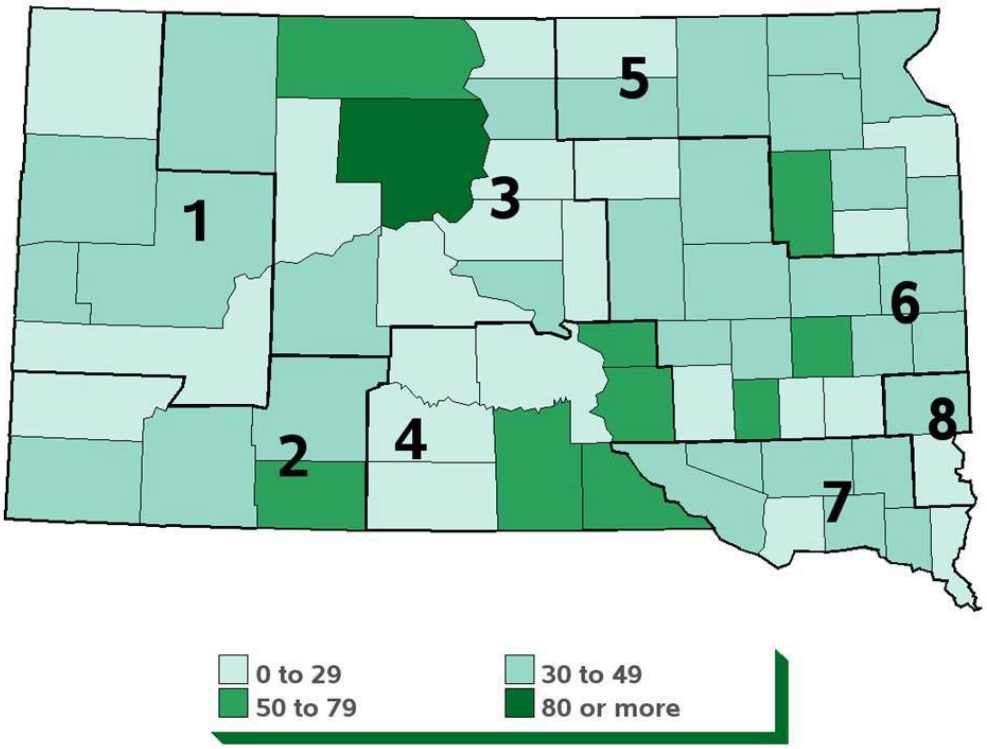
Source: Abt Associates' analysis of South Dakota's III-C sites data; includes senior nutrition projects funded by Title III-C and/or Title VI (Older Americans Act direct funding to the tribes).

Exhibit 36. Number of DSS-Affiliated Homemaker Agencies Located in Each County, South Dakota, 2014



Source: Abt Associates' analysis of South Dakota's In-home provider agencies data; includes only homemaker agencies with existing relationship with DSS. While every county is served by at least one DSS-affiliated homemaker agency, 36 counties have no DSS-affiliated homemaker agencies located within their borders.

Exhibit 37. In-Home Service Clients per 1,000 Elderly Individuals by County, South Dakota, 2014



Source: Abt Associates' analysis of South Dakota's HCBS Consumers data; includes only consumers served by DSS-affiliated providers.

5. Projecting Future Demand for Long-Term Care Services

As described in greater detail in the methods section, we developed several forecast scenarios to describe projected future demand for LTC services under a variety of assumptions about future utilization rates. Unlike the projections in the prior 2007 report, these updated projections are based on actual State-level trends from 2010 through the present; in the prior report, historical trend data were unavailable at the State level, so our forecasts necessarily relied on national trend data only. In this sense, these updated projections represent an improvement on our prior forecast methodology, as they are based on more complete local knowledge.

In particular, we developed three alternative forecast scenarios, described in greater detail in Section 2.3:

Scenario A: Baseline/Status Quo. Under this baseline scenario, we assume that nursing home and assisted living utilization rates hold fixed at average 2010-2014 levels as described under Task 3[9]:

- Nursing home utilization as percent of elderly population = 4.7 percent
- Assisted living utilization as percent of elderly population = 2.6 percent

Scenario B: Nursing home utilization continues to decline at a moderated rate. Under this alternative scenario, a decline in disability and substitution to assisted living and HCBS contribute to a continued decline in nursing home utilization at approximately half the rate of recent declines.

- Nursing home utilization falls at a rate of 0.09 percentage points per year, or approximately one half the 2000-2014 rate of decline.
- The decline in nursing home utilization is partially offset by a rise in the assisted living utilization rate, with the lowest functional status individuals who would otherwise have resided in nursing homes instead entering assisted living, and the remainder remaining in the community.

Scenario C: Nursing home utilization continues to decline at a rapid pace, converging to national average rates by 2035. Under this alternative scenario, aggressive state policy encouraging further substitution of assisted living and HCBS continues to drive nursing home utilization rates down at a rapid pace.

- Nursing home utilization falls at a rate of 0.14 percentage points per year, reaching a rate of 1.2 percent by 2035.
- The decline in nursing home utilization is partially offset by a rise in the assisted living utilization rate, with the lowest functional status individuals who would otherwise have resided in nursing homes instead entering assisted living, and the remainder remaining in the community.

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[9] This projection scenario methodology mirrors the baseline projections provided in the 2007 Final Report to enable direct comparison. However, we note that, given the recent sharp decline in nursing home utilization in South Dakota as described above, it appears unlikely that future nursing home utilization rates will in fact remain fixed at this level as assumed. The two alternative future scenarios, which assume continued declines in utilization rates moving forward, may therefore more realistically depict actual future trends.

5.1 Projected Demand for Nursing Home Care

Exhibit 38 provides estimates of projected growth in nursing home utilization through the year 2035 under the baseline scenario, which as noted above assumes utilization rates hold constant at 2010-2014 levels. As noted above, this simple assumption may be unrealistic given the continued sharp decline in utilization rates we have seen in recent years across the state; however, we present the results of the baseline model to enable direct comparison with the prior report.

Note that because utilization rates are assumed to be unchanged, these baseline forecasts are driven entirely by growth in the elderly population over time and do not take into account the state's current nursing home bed moratorium, or possible future changes in disability rates, family composition, income, or other factors potentially influencing utilization. Under this simple projection methodology, the nursing home population is projected to rise to 10,595 by the year 2035, a 72% increase from average 2010-2014 levels.

Exhibit 38. Projected South Dakota Nursing Home Utilization Rates under Scenario A (Baseline) – Utilization Rates Hold Constant at 2010-2014 Average

	Elderly Population	Elderly Disabled Population	Nursing Home Population	As % of Elderly Population	As % of Disabled Elderly Population
Actual Nursing Home Utilization:					
2000	108,131	46,957	6,974	6.4%	14.9%
2005	119,313	51,783	6,732	5.6%	13.0%
2010 - 2014	131,526	49,514	6,173	4.7%	12.5%
Projected Nursing Home Utilization:					
2015	144,575	49,129	6,785	4.7%	13.8%
2020	171,527	62,211	8,050	4.7%	12.9%
2025	198,542	71,120	9,318	4.7%	13.1%
2030	218,886	84,857	10,273	4.7%	12.1%
2035	225,744	82,812	10,595	4.7%	12.8%

Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, American Community Survey data, and Nursing Home Compare data.

The baseline scenario assumes that nursing home utilization rates will remain unchanged. In contrast, recent years have seen a relatively steep decline in nursing home utilization rates in South Dakota (a drop from 6.4 percent to 4.7 percent between 2000 and average 2010-14 levels), and it seems reasonable to expect that this decline will continue. The two alternative projection scenarios we consider therefore incorporate more realistic assumptions, and assume a continued future decrease in utilization rates.

However, it is unclear whether or not the current rate of decline is sustainable: at some point, only individuals with fairly extensive functional limitations will remain in nursing homes, and such individuals may not be able to receive appropriate care in alternative settings. We therefore consider two alternative scenarios for the projected rate of decline: Scenario B assumes that the rate of decline

will moderate over the coming decades to one half the current rate, while Scenario C assumes a continued rapid pace of decline, with South Dakota ultimately converging to national utilization rates in the year 2035.

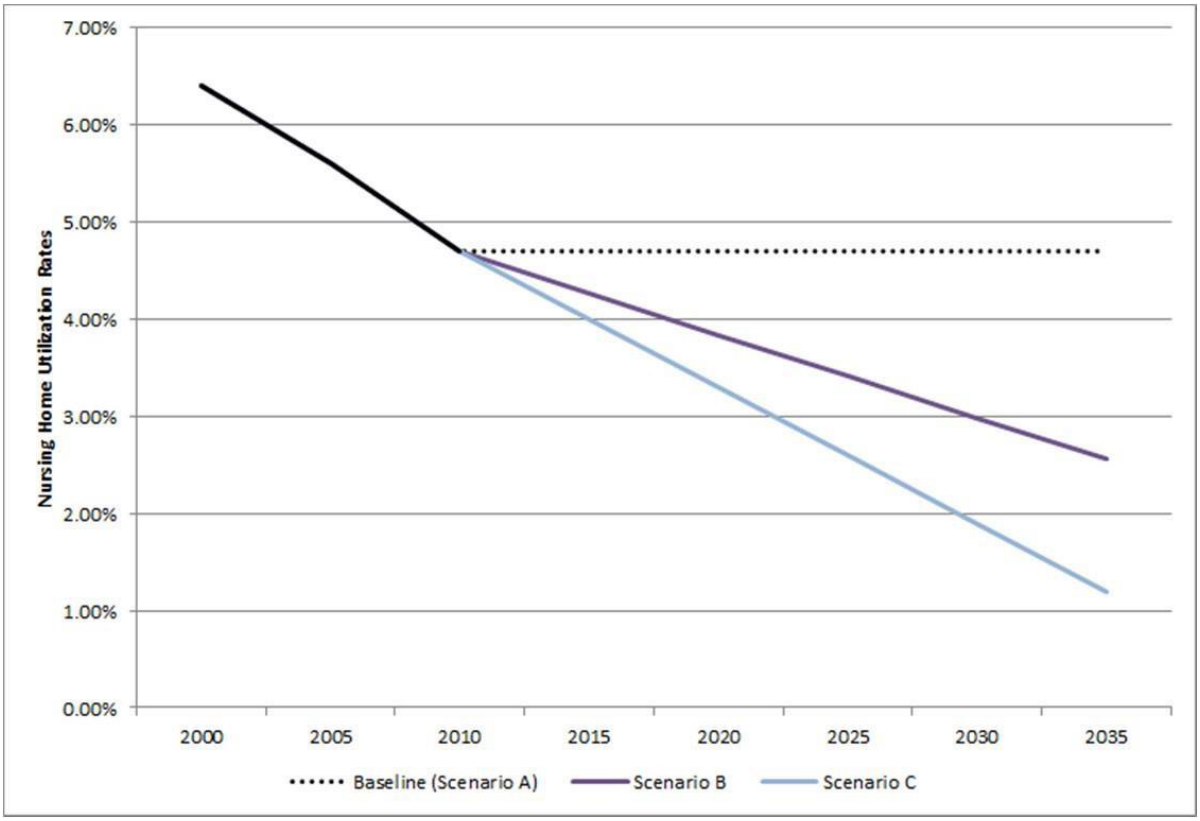
Exhibit 39 summarizes projected nursing home utilization rates for the year 2035 under the three scenarios, and Exhibit 40 graphically depicts time trends in nursing home utilization rates under each scenario from 2000 through 2035. Under the baseline scenario, the nursing home utilization rate stays fixed at its current rate of 4.7 percent through 2035, while under Scenarios B and C, it falls to 2.6 percent and 1.2 percent, respectively.

Exhibit 39. Projected South Dakota Nursing Home Utilization Rates, 2035

As % of Disabled Estimated Nursing Home Population		As % of Elderly Population	Elderly Population
Baseline Scenario A: Flat Utilization Rates	10,595	4.69%	12.79%
Alternative Scenario B: Nursing home utilization falls at a rate equal to recent trends	5,776	2.56%	6.98%
Alternative Scenario C: Nursing home utilization falls to the national average by 2035	2,709	1.20%	3.27%

Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, American Community Survey data, and Nursing Home Compare data.

Exhibit 40. Projected South Dakota Nursing Home Utilization Rates; 3 Scenarios, 2000 – 2035

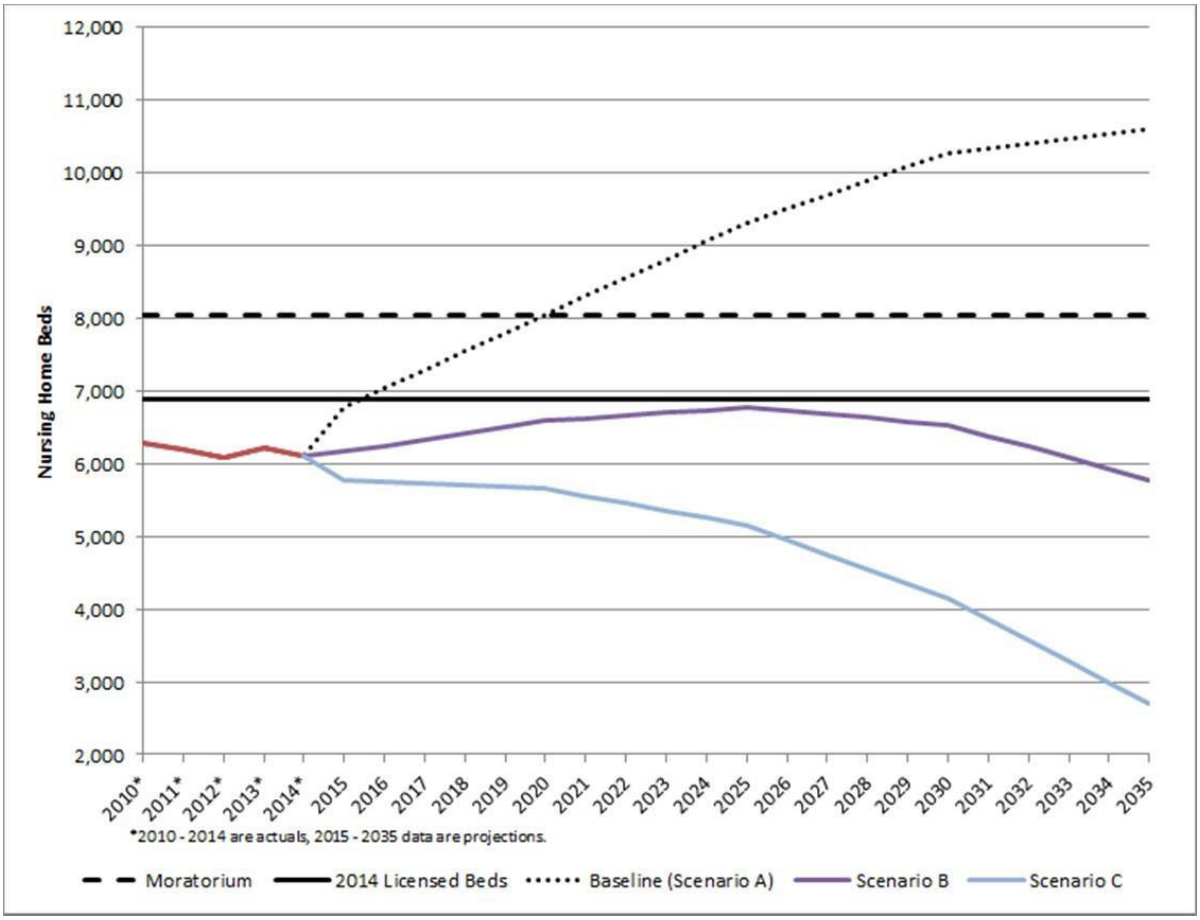


Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, American Community Survey data, and Nursing Home Compare data.

Exhibit 41 shows projections for total nursing home population for each scenario consistent with these projected utilization rates. Notice that while under the baseline scenario, the nursing home population continues to rise through 2035 with the increase in the elderly and elderly disabled populations, under the two alternative scenarios the population is actually forecast to *decrease* by 2035. These projected decreases occur when the declining utilization rate falls far enough to compensate for the continued increase in the elderly and disabled elderly populations. In particular, under Scenario B, the projected nursing home population reaches a maximum of 6,776 in the year 2025 before declining to 5,776 in 2035; under Scenario C, the projected nursing home population declines continually from its current level to reach 2,709 in 2035.

Finally, note that while demand for nursing home beds will soon exceed available moratorium beds under Scenario A, in contrast, if utilization rates continue to decline as projected under Scenarios B and C, demand will remain well below moratorium levels.

Exhibit 41. Forecast Demand for South Dakota Nursing Home Beds, 3 Scenarios, 2000 – 2035



Source: Abt Associates' analysis of South Dakota's Nursing Facilities data and South Dakota Department of Social Services' Nursing Home Occupancy Report.

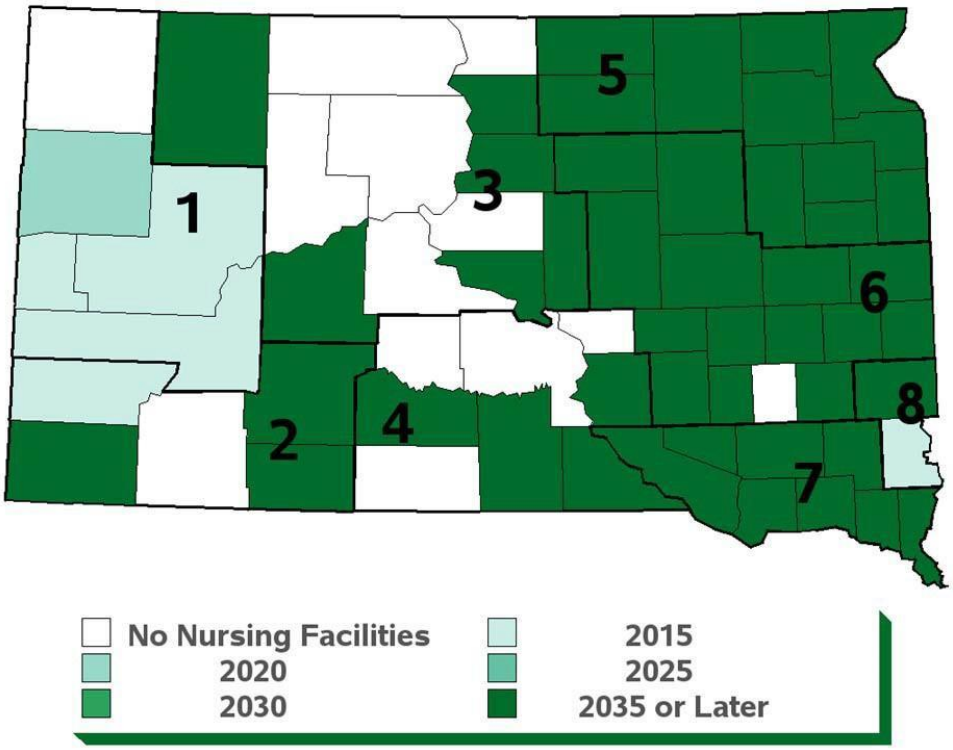
In the remainder of this section, we focus primarily on future projections under Scenario B, which makes more conservative assumptions about the future rate of decline in nursing home utilization than Scenario C, while still assuming that decline will continue as seems most likely, unlike the assumption of fixed utilization rates under Scenario A.

As Exhibit 42 illustrates, there is substantial geographic variation in the projected gap between supply and demand across the State, and even across closely-adjacent counties.

Counties in the Rapid City area, which as noted above is projected to experience high growth in elderly and disabled elderly populations, face a particularly acute need, with demand projected to exceed supply of moratorium beds in surrounding counties as soon as 2015 under both Scenarios A and B, and by 2020 under Scenario C, which assumes a more rapid decline in utilization rates. In the Sioux Falls area, also expected to face rapid growth in elderly and disabled elderly populations, Lincoln County also faces acute supply constraints, with demand exceeding moratorium beds in 2015 under all three scenarios, although demand in neighboring Minnehaha County is slightly less acute, with demand exceeding moratorium beds in 2015 under Scenario A only, but not until 2020 under Scenario B and not until 2025 under Scenario C.

A substantial number of counties in the eastern and central parts of the state are not expected to become supply-constrained before 2035.

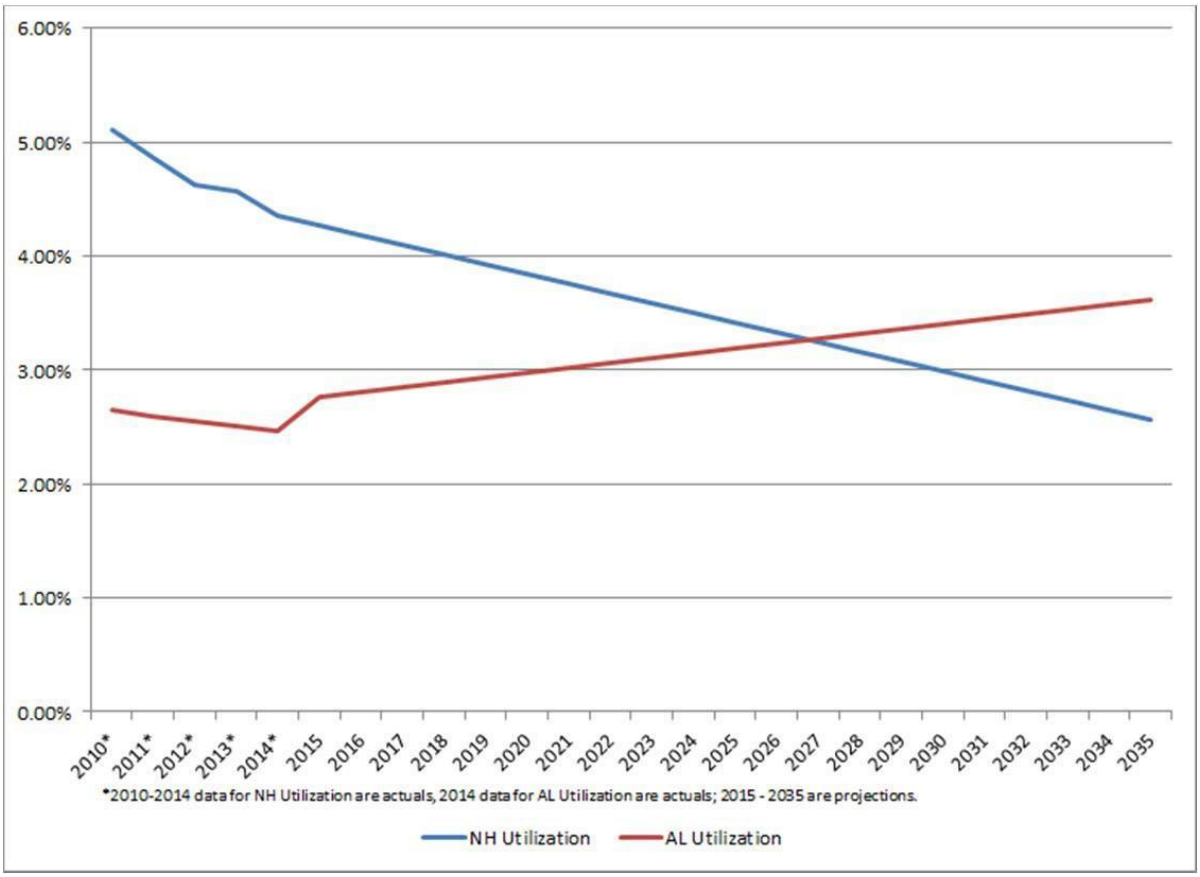
Exhibit 42. Under Scenario B, When Does South Dakota County-Level Demand Exceed Supply of Moratorium Beds?



5.2 Projected Demand for Assisted Living

Under our two alternative scenarios, the decline in nursing home utilization is assumed to be partially offset by an increase in assisted living utilization. Exhibit 43 shows how use of assisted living services must rise as nursing home utilization is reduced. We present results for Scenario B, since it is a mid-point forecast; under this scenario, assisted living utilization rates would rise from 2.6% in the year 2000 to 3.6% in 2035.

Exhibit 43. Substitution between Assisted Living and Nursing Home Care in South Dakota: Scenario B

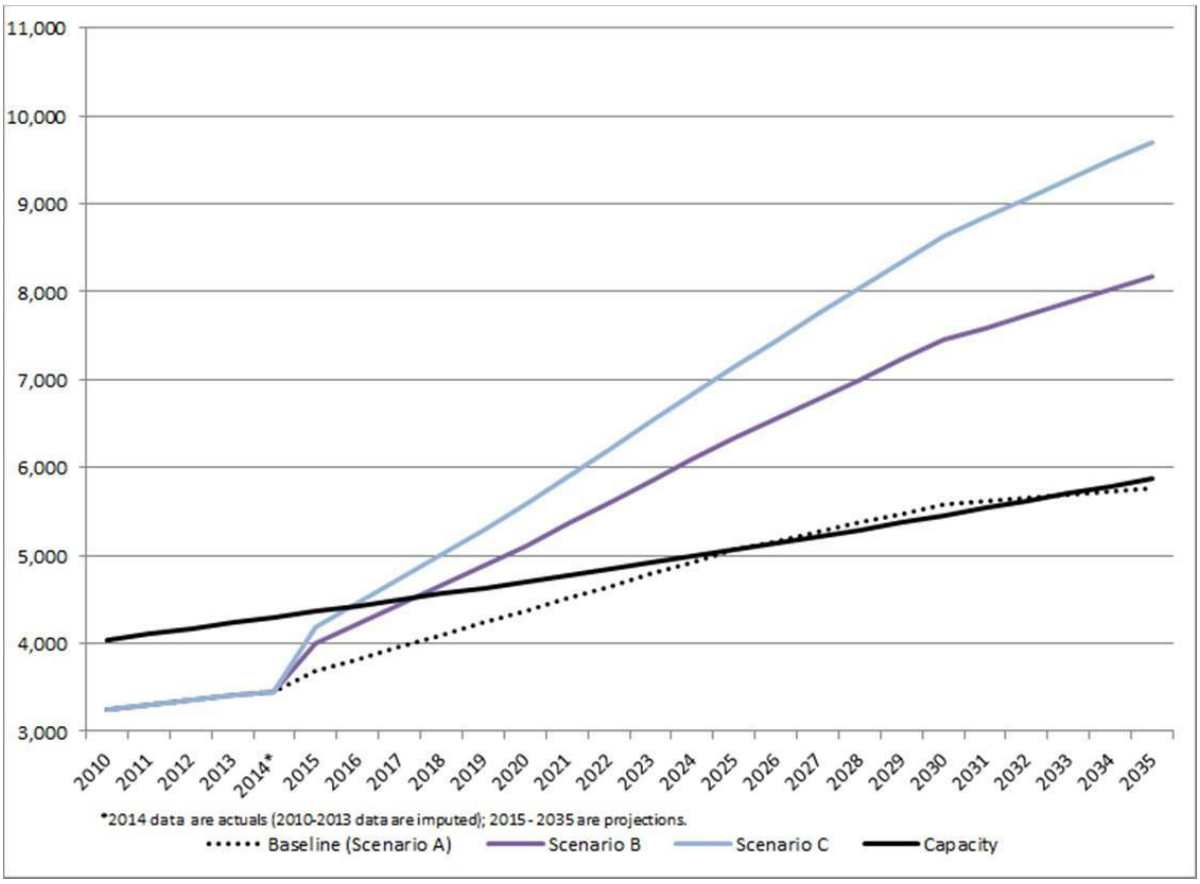


*2010 – 2014 represents the average utilization over that time period.

Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, South Dakota's Nursing Facilities data, Nursing Home Compare data, and South Dakota's Assisted Living Facilities data.

Exhibit 44 shows how projected assisted living utilization rates under each scenario translate to demand for assisted living beds. Under the baseline Scenario A, projected demand for beds will only marginally exceed supply so long as capacity continues to increase in line with its recent 1.5% annual trend; from 2025 to 2030 projected demand is just slightly higher than projected capacity, but by 2035 the gap closes once more. However, if nursing home utilization rates decline consistent with our more reasonable assumptions under the two alternative scenarios, demand for assisted living beds will exceed supply well before 2020.

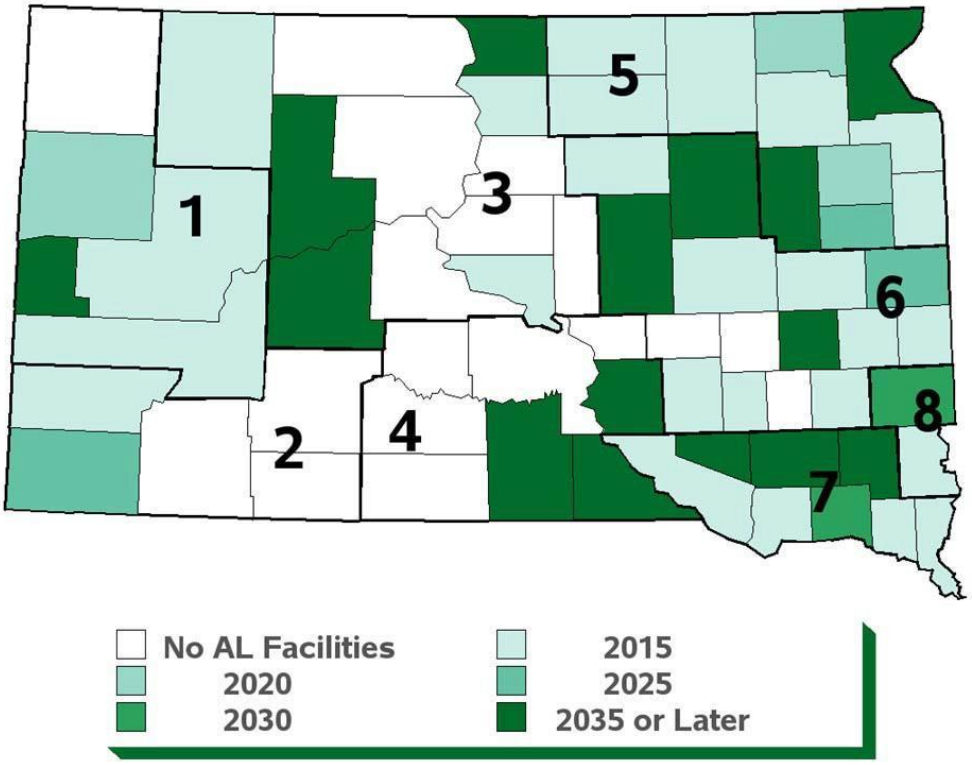
Exhibit 44. Projected Supply and Demand of Assisted Living Beds, South Dakota, 2000 – 2035



Source: Abt Associates' analysis of South Dakota's Assisted Living Facilities data.

Exhibit 45 shows geographic variation in the projected gap between supply of and demand for assisted living beds by county. As with nursing homes, supply constraints appear to be somewhat more acute in the western and central part of the State.

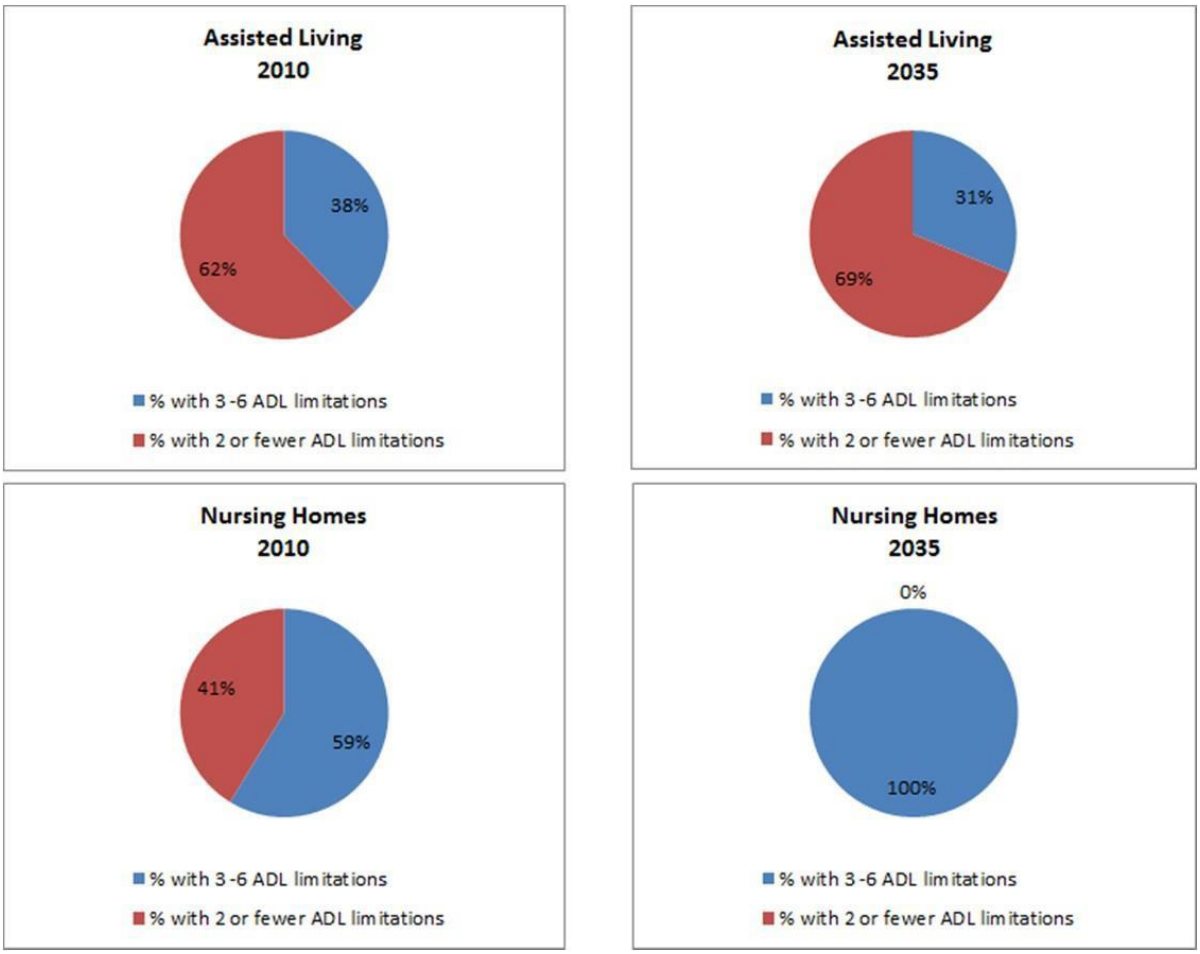
Exhibit 45. Under Scenario B, When Does South Dakota County-Level Demand Exceed Supply of Assisted Living Beds?



Source: Abt Associates' analysis of South Dakota's Assisted Living Facilities data.

As nursing home utilization rates fall, only those with the greatest functional limitations will remain in the nursing home setting, with individuals of higher functional status moving to other forms of care such as assisted living or HCBS. Exhibit 46 compares patient complexity in terms of ADL limitations within assisted living and nursing home settings between 2010 (actual) and 2035 (projected). Under Scenario B, we project that the great majority of individuals with 2 or fewer ADL limitations will exit nursing home settings by the year 2035, along with a sizable number of individuals with 3 or more functional limitations as nursing home capacity becomes too constrained to serve their needs. While actual differences in functional status across settings may not be as stark as our projections suggest, the fact remains that, if nursing home utilization continues to decline, even at a moderated rate as under Scenario B, by 2035 the number of individuals with 3 or more functional limitations will exceed the number of individuals accommodated in nursing homes. Future efforts to continue reduction of nursing home utilization should include protections to ensure those in greatest need of clinical and functional support can still access appropriate care in nursing home settings.

Exhibit 46. Changing Complexity of Residents in South Dakota Nursing Homes and Assisted Living, 2010 – 2035



Source: Abt Associates' analysis of South Dakota's Assisted Living Facilities data, Nursing Facilities data, and Nursing Home Compare data.

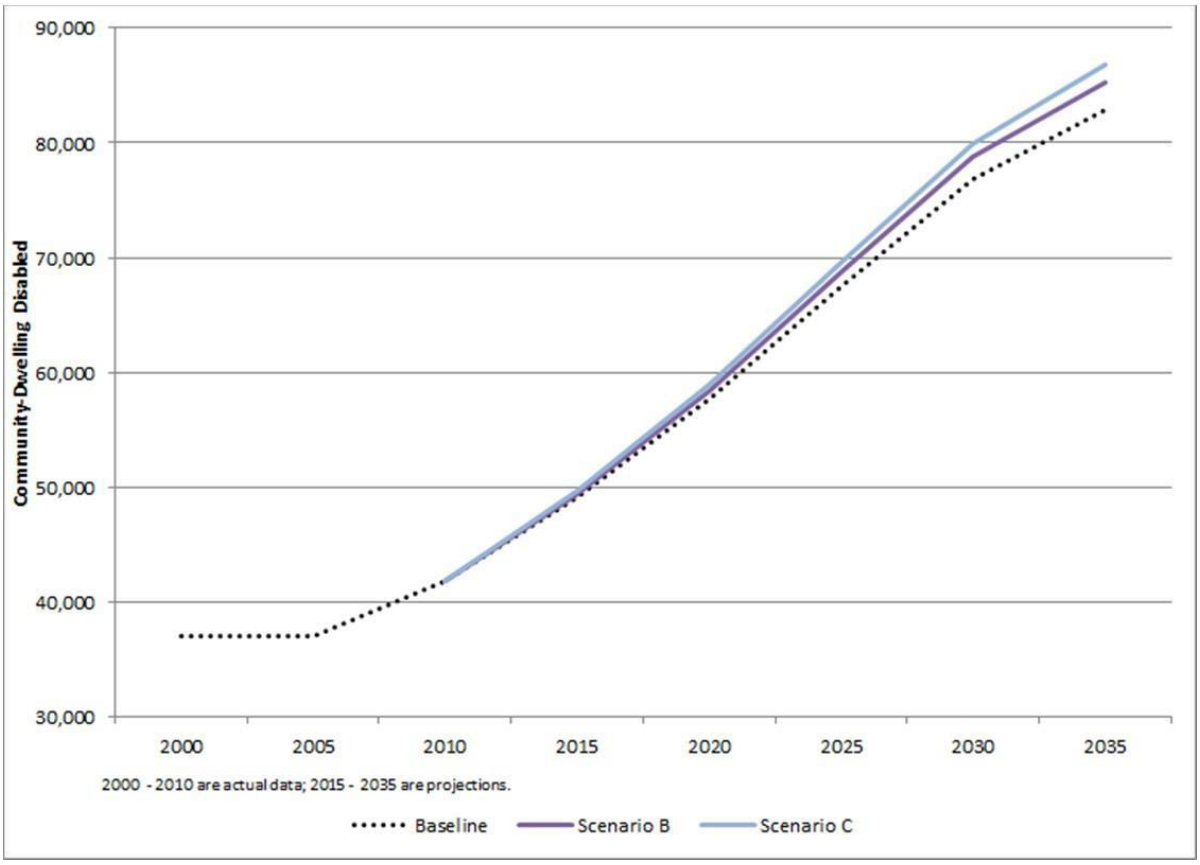
5.3 Home and Community Based Services

As in our prior report, in all scenarios considered, the numbers of community-dwelling disabled seniors will increase, driven by population changes, higher projected health levels, individual preferences, or policy changes that could promote increases in home and community based care options.

Exhibit 47 depicts the increase in community-based disabled seniors under the baseline forecast and the two alternative scenarios, which assume aggressive efforts to rebalance care will continue. Under all scenarios, the community-dwelling senior population will rise by approximately 40,000-45,000 by the year 2035.

As seen in Sections 4.3 and 4.4, we see little evidence of substantial increases in provision of HCBS relative to levels observed in our 2007 report, and South Dakota continues to lag behind national averages. It is clear that further aggressive rebalancing efforts will be required to support increasing numbers of community-dwelling seniors in the future.

Exhibit 47. Numbers of Community-Dwelling Seniors in South Dakota Will Rise, 2000 – 2035



Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data and American Community Survey data.

6. Conclusions

It is clear that recent policy changes in South Dakota as described in the introduction have successfully accelerated the decline in nursing home utilization, substantially reducing the gap relative to national utilization rates. Assisted living utilization has increased in parallel, but we do not observe concurrent increases in skilled Medicare home health or HCBS.

These results naturally lead to speculation on how the needs of individuals are being met in light of decreasing nursing home utilization without a correlating increase in the use of formal supports. Per the Department of Social Services, South Dakota ranked within the top five states nationwide in market penetration for private long term care insurance as of June 2013, potentially indicating one way in which residents are bridging the gap. Increased use of informal supports by family and friends may also play a role, though we cannot formally assess this possibility in the context of this report.

Under all hypothetical future scenarios considered, further efforts will be required to meet future demand for LTC services outside the nursing home setting. The State must clearly maintain its focus on rebalancing the long-term services and supports systems (LTSS), through:

- Continuing to utilize options counseling through the ADRC to educate consumers and families about community-based care alternatives, in attempts to reduce nursing home admissions;
- Continuing to expand and enhance the availability of HCBS and potentially State Plan-funded community-based care; and
- Exploration of the care preferences and knowledge base of elders and their caregivers, as well as gathering information on the informal support networks that people are currently utilizing in lieu of seeking assistance from state programs.

Attachment H AARP Score Card

South Dakota: 2014 State Long-Term Services and Supports Scorecard Results

Raising Expectations 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers takes a multi-dimensional approach to measure state-level performance of long-term services and supports (LTSS) systems that assist older people, adults with disabilities, and family caregivers. The full report is available at www.longtermscorecard.org

Purpose: The *Scorecard* measures system performance from the viewpoint of service users and their families. It is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in *all* states can exercise choice and control over their lives, thereby maximizing their independence and well-being. State policymakers often control key indicators measured, and they can influence others through oversight activities and incentives.

Results: The *Scorecard* examines state performance, both overall and along five key dimensions. Each dimension comprises 3 to 6 data indicators, for a total of 26. It also measures changes in performance since the first *Scorecard* (2011), wherever possible (on 19 of the 26 indicators). The table below summarizes current performance and change in performance at the dimension level. State ranks on each indicator appear on the next page.

Dimension	Rank	Number of indicators with trend *	Number of indicators showing: **		
			Substantial improvement	Little or no change	Substantial decline
OVERALL	**24**	**19**	**6**	**11**	**2**
Affordability & Access	40	6	2	3	1
Choice of Setting & Provider	43	4	2	1	1
Quality of Care & Quality of Life	5	4	1	3	0
Support for Family Caregivers	13	3	1	2	0
Effective Transitions	24	2	0	2	0

* Trend cannot be shown if data are missing for either the current or baseline data year. In each state, 16 to 19 indicators have enough data to calculate a trend. ** See full report for how change is defined.

Impact of Improved Performance: If South Dakota improved its performance to the level of the highest performing state:

- 5,992 more low/moderate-income adults with ADL disabilities would be covered by Medicaid.
- 933 more new users of Medicaid LTSS would first receive services in the community.
- 1,032 nursing home residents with low care needs would instead receive LTSS in the community.
- 289 more people entering nursing homes would be able to return to the community within 100 days.
- 705 more people who have been in a nursing home for 90 days or more would be able to move back to the community.

South Dakota: 2014 State Long-Term Services and Supports Scorecard Dimension and Indicator Data

Dimension and Indicator (Current Data Year)	Baseline Rate	Current Rate	Rank	Change	All States Median	Top State Rate
OVERALL RANK			**24**			
Affordability and Access			**40**			
Median annual nursing home private pay cost as a percentage of median household income age 65+ (2013)	223%	**215%**	**18**	↑	234%	168%
Median annual home care private pay cost as a percentage of median household income age 65+ (2013)	100%	**95%**	**42**	↑	84%	47%
Private long-term care insurance policies in effect per 1,000 population age 40+ (2011)	110	**112**	**2**	↑	44	130
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance (2011-12)	45.7%	**42.3%**	**51**	✘	51.4%	78.1%
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community (2009)	28.1	**36.5**	**28**	✓	42.3	85.2
ADRC functions (composite indicator, scale 0-70) (2012)	**	**50**	**33**	✓	54	67
Choice of Setting and Provider			**43**			
Percent of Medicaid and state LTSS spending going to HCBS for older people & adults w/ physical disabilities (2011)	14.0%	**17.0%**	**49**	✓	31.4%	65.4%
Percent of new Medicaid aged/disabled LTSS users first receiving services in the community (2009)	24.9%	**26.8%**	**42**	✓	50.7%	81.9%
Number of people participant-directing services per 1,000 adults age 18+ with disabilities (2013)	*	**10.2**	**25**	*	8.8	127.3
Home health and personal care aides per 1,000 population age 65+ (2010-12)	18	**13**	**51**	✘	33	76
Assisted living and residential care units per 1,000 population age 65+ (2012-13)	34	**34**	**13**	↑	27	125
Quality of Life and Quality of Care			**5**			
Percent of adults age 18+ with disabilities in the community usually or always getting needed support (2010)	76.2%	**75.3%**	**8**	↑	71.8%	79.1%
Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life (2010)	92.4%	**92.1%**	**1**	↑	86.7%	92.1%
Rate of employment for adults with ADL disability ages 18–64 relative to rate of employment for adults without ADL disability ages 18–64 (2011-12)	31.5%	**37.2%**	**1**	✓	23.4%	37.2%
Percent of high-risk nursing home residents with pressure sores (2013)	*	**4.8%**	**10**	*	5.9%	3.0%
Nursing home staffing turnover: ratio of employee terminations to the average number of active employees (2010)	46.4%	**42.8%**	**30**	↑	38.1%	15.4%
Percent of long-stay nursing home residents who are receiving an antipsychotic medication (2013)	*	**19.0%**	**18**	*	20.2%	11.9%
Support for Family Caregivers			**13**			
Legal and system supports for family caregivers (composite indicator, scale 0-14.5) (2012-13)	**	**2.70**	**28**	↑	3.00	8.00
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2013)	11	**11**	**20**	↑	9.5	16
Family caregivers without much worry or stress, with enough time, well-rested (2011-12)	60.6%	**64.5%**	**4**	✓	61.6%	72.8%
Effective Transitions			**24**			
Percent of nursing home residents with low care needs (2010)	17.0%	**16.7%**	**40**	↑	11.7%	1.1%
Percent of home health patients with a hospital admission (2012)	*	**22.9%**	**6**	*	25.5%	18.9%
Percent of long-stay nursing home residents hospitalized within a six-month period (2010)	15.8%	**15.6%**	**17**	↑	18.9%	7.3%
Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life (2009)	*	**14.3%**	**10**	*	20.3%	7.1%
Percent of new nursing home stays lasting 100 days or more (2009)	*	**19.5%**	**25**	*	19.8%	10.3%
Percent of people with 90+ day nursing home stays successfully transitioning back to the community (2009)	*	**5.2%**	**49**	*	7.9%	15.8%

* Comparable data not available for baseline and/or current year. Change in performance cannot be calculated without baseline and current data.
** Composite measure. Baseline rate is not shown as some components of the measure are only available for the current year. Change in performance is based only on those components with comparable prior data. See page 73 and page 83 in *Raising Expectations 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* for more detail. Notes: ADL = Activities of Daily Living; ADRC = Aging and Disability Resource Center; HCBS = Home and Community Based Services; LTSS = Long Term Services and Supports.
Please refer to Appendix B2 on page 97 in the report for full indicator descriptions, data sources, and other notes about methodology; for baseline data years, please see Exhibit 2 on page 11. The full report is available at www.longtermscorecard.org

Key for Change:	
✓	Performance improvement
1	Little or no change in performance
✗	Performance decline

Attachment I
Aging and Disability Resource Connections

Partners

Partner	Partner Focus	Partner Type	Collaborative Working Relationship
South Dakota Department of Social Services (DSS), Division of Behavioral Health	Ensure children and adults with mental health disorders and chemical dependency issues have the opportunity to choose and receive effective services and recovery (Community Behavioral Health).	Core Partner	Reciprocal referrals of consumers and information sharing on ADRC processes to include intake, assessment, eligibility determination, and ASA Programs on long-term services and supports.
South Dakota DSS, Division of Medical Services	Assistance to individuals who qualify for Medicaid by providing health insurance and payment of medical services.	Core Partner	Collaboration on referrals for long-term care and information sharing on Health Homes, Money Follows the Person, and ASA Programs on long-term services and supports.
South Dakota DSS, Division of Economic Assistance	Provides medical, nutritional, financial and case management services to lower income families, people with disabilities, children and the elderly. Assistance programs include: Community Action Programs, Supplemental Nutrition Assistance Program (SNAP), Energy and Weatherization Assistance, Medical Eligibility, Temporary Assistance for Needy Families (TANF) and Quality	Core Partner	Collaboration on referrals for long-term care and financial eligibility determinations. Referrals for services available through Community Action Programs, SNAP, Energy and Weatherization Assistance, Medical Eligibility and TANF.

SD Department of Transportation	Provides close coordination in matters pertaining to transportation services for the elderly and individuals with disabilities.	Core Partner	Disseminate information on transportation programs to agencies providing or interested in providing special transportation services and/or public transportation. Reciprocal referrals of consumers and information sharing on processes to include intake, eligibility determination, service
South Dakota Department of Human Services (DHS), Division of Rehabilitation	Provides services to individuals with disabilities to obtain and maintain employment.	Core Partner	Reciprocal referrals of consumers and information sharing on ADRC processes to include intake, assessment, eligibility determination, and ASA Programs on long-term services and supports.
South Dakota DHS, Division of Developmental Disabilities	Provides community based services to individuals with an intellectual/developmental disability and their families.	Core Partner	Reciprocal referrals of consumers and information sharing on ADRC processes to include intake, assessment, eligibility determination, and ASA Programs on long-term services and supports.

Senior Health Information and Insurance Education (SHIINE	Free, confidential and unbiased assistance to Medicare beneficiaries and their families through education, counseling, and outreach to better understand, identify programs and plans and utilize Medicare benefits.	Core Partner	Reciprocal referrals of consumers and information sharing on ADRC processes to include intake, assessment, eligibility determination, and ASA Programs on long-term services and supports.
Statewide Independent Living Council	Serves as an advocate for individuals with significant disabilities needing independent living services.	Community Partner	Information sharing on ADRC processes to include intake, assessment, eligibility determination, case management, and ASA Programs on long-term services and supports.
South Dakota Coalition of Citizens with Disabilities	Advocates for the full inclusion of all individuals with disabilities and provides resources and advocacy and is a single point of contact on disability issues.	Community Partner	Information sharing on disability issues.

Mental Health Centers	Provides community based services to adults with severe and persistent mental illness (medical, social, education, vocational, crisis intervention).	Community Partners	Reciprocal referrals of consumers and information sharing on ADRC processes to include intake, assessment, eligibility determination, and ASA Programs on long-term services and supports.
Centers for Independent Living	Provides services to individuals with disabilities living in the community.	Community Partners	Reciprocal referrals of consumers and information sharing on ADRC processes to include intake, eligibility determination, and ASA Programs on long- term
In-Home Service Providers	Provides in-home services including homemaker, personal care, nursing services, assistive devices, specialized medical equipment and supplies, emergency response systems, meals, nutritional supplements to individuals living at home.	Community Partners	Information sharing on ADRC process to include intake, assessment, eligibility determination, case management, and ASA Programs on long-term services and supports. Reciprocal referrals of consumers.

Nursing Facilities	Provides institutional long-term care services.	Critical Pathway Partners	Reciprocal referrals of consumers and information sharing on ADRC processes to include intake, eligibility determination, service provision, provided information/training on Section Q. Informal linkages/collaborative working relationships.
Hospital/ Discharge Planners	Provides discharge planning to individuals discharging from a hospital.	Critical Pathway Partners	Referrals of consumers and information sharing on ADRC processes, i.e., intake, eligibility determination. Informal linkages/collaborative working relationships established. ADRC brochure and DSS/ASA Program brochures.

County Human Services/Welfare	Provides assistance to individuals in the community.	Community Partners	Reciprocal referrals of consumers and information sharing on ADRC processes to include intake, eligibility determination, assessment and ASA Programs on long-term services and supports.
211 Helpline Center	Provides information on South Dakota community resources via website and 211 Helpline to "strengthen individuals, families, and community by bridging people with resources and support”.	Community Partner	Reciprocal referrals of consumers and information sharing on ADRC processes to include intake, assessment, eligibility determination, case management, and ASA Programs on long-term services and supports.
Indian Health Services	Provides inpatient and outpatient health care and preventive and curative clinics to Indians on South Dakota reservations and operates service units that include hospitals, health centers, school health stations, and smaller health stations and satellite clinics.	Community Partners	Reciprocal referrals of consumers and information sharing on ADRC processes to include intake, assessment, eligibility determination, and ASA Programs on long-term services and supports.

Tribal Offices	Cheyenne River Sioux, Crow Creek Sioux, Flandreau Santee Sioux, Lower Brule Sioux, Oglala Sioux, Rosebud Sioux, Sisseton-Wahpeton Sioux, Standing Rock Sioux and Yankton Sioux Tribes provide various levels and types of assistance to tribal members ranging from tribal social services, mental health, vocational rehabilitation, personal care services, homemaker services, etc.	Community Partners	Reciprocal referrals of consumers and information sharing on ASA Programs on long-term services and supports.
SD State Advisory Council on Aging	Reviews and evaluates Programs and Services and makes recommendations to the South Dakota Department of Social Services, Division of Adult Services and Aging on improving services provided to older South Dakotans.	Community Partner	ASA staff provides informational updates on ADRC process and ASA Programs on long-term services and supports to members at Council meetings.
South Dakota AARP	Provides information from health issues, identity theft and fraud to community events targeting adults over 50	Community Partner	Referral of individuals to ASA Programs and services.

SD Association of Healthcare Organizations (SDAHO)	Represents and serves health care organizations through advocacy, information, education and networking with a diverse range of membership, i.e., and nursing facilities, home health agencies, assisted living, and hospice.	Community Partner	ASA staff provides informational updates on the ADRC and ASA Programs on long-term services and supports to members at quarterly Council on Home Care meetings and annual
SD Health Care Association (SDHCA)	Represents long-term care organizations including skilled nursing care, assisted living in SD to improve the quality of long- term care through advocacy, communication, professional education.	Community Partner	ASA staff provides informational updates on the ADRC and ASA Programs on long-term services and supports to members at annual SDHCA conventions.
South Dakota Nutrition Association	Represents nutrition programs by advocating for nutritious meals for disabled and elderly adults.	Community Partner	ASA staff provides informational updates on the ADRC and ASA Programs on long-term services and supports to members. Reciprocal referrals of
Assisted Living Association of South Dakota (ALASD)	Represents assisted living centers to improve community-based health care throughout South Dakota.	Community Partner	ASA staff provides informational updates on the ADRC and ASA Programs on long-term services and supports to members.

Senior Centers	Non-profit organizations that offer adults of all ages with opportunities to support independence and encourage community involvement. Individuals receive information, education, and services in the areas of education, physical and mental health, nutrition, and social and recreational activities to positively affect quality of life.	Community Partner	Collaboration between Senior Centers and ASA to hold informational and educational presentations on the ADRC and ASA Programs and Services at Senior Centers in various cities and towns across the state.
			Partnered with one senior center during the South Dakota State Fair to provide information and education on the ADRC and ASA Programs and Services in the Senior Center's building on the grounds of the State Fair.

Attachment J

South Dakota Elder Abuse Task Force

Final Report and Recommendations

December 2015

Introduction

The South Dakota Elder Abuse Task Force was the creation of Senate Bill 168, passed during the 2015 Legislative Session. The South Dakota Legislature vested the Task Force with a two-pronged mission: "to study the prevalence and impact of elder abuse in South Dakota and to make recommendations to the Legislature on policies and legislation to effectively address the issue." To accomplish these ends, the Legislature allotted seventeen seats on the Task Force:

- Three members of the Senate chosen by the President Pro Tempore:
  - **Sen. James Bradford**
  - **Sen. David Novstrup**
  - **Sen. Bruce Rampelberg**
- Three members of the House of Representatives chosen by the Speaker of the House of Representatives:
  - **Rep. Brian Gosch**
  - **Rep. Kris Langer**
  - **Rep. Lee Schoenbeck**
- Three members chosen by the Governor "who have significant experience working with issues related to elder abuse":
  - **Sarah Dahlin Jennings** (South Dakota State Director – AARP)
  - **Jennifer Murray** (Regional Manager, DSS – Adult Services & Aging)
  - **Robert Kean** (Attorney and Fmr. Exec. Director of South Dakota Advocacy Services)
- Seven members appointed by the Chief Justice of the Supreme Court, specifically "five members who have significant experience working with issues related to elder abuse and two members from the banking industry":
  - **Justice Steven L. Zinter** (South Dakota Supreme Court)
  - **Dr. Victoria Walker** (Chief Medical & Quality Officer, The Evangelical Lutheran Good Samaritan Society)
  - **Quentin Riggins** (Attorney and Chair of the Real Property, Probate & Trust Law Section, State Bar of South Dakota)
  - **Tim Neyhart** (Executive Director, South Dakota Advocacy Services)

- **Dr. David Brechtelsbauer** (Physician, Geriatrician, and Clinical Faculty at the USD Sanford School of Medicine)
- **Rick Rylance** (Regional President, Dacotah Bank)
- **Kristina Schaefer** (Vice President – General Counsel & Dir. of Risk Management, Fishback Financial Corporation)

- One member "who has significant experience working with issues related to elder abuse" appointed by the Attorney General:
  - **Paul Cremer** (Assistant Attorney General & Division Director, Medicaid Fraud Control Unit)

The Legislature gave the Task Force six months to complete its task. In that time, the Task Force selected a Chair – Justice Steven Zinter – and formed four Committees to focus on specialized areas of interest on the broad topic of elder abuse: (1) Elder Abuse and Neglect, (2) Elder Financial Exploitation, (3) Education, and (4) Guardianships, Wills, and Powers of Attorney.

The Task Force met four times as a group. Public input was solicited and received at all meetings. In between the full group meetings, the Committees conducted numerous teleconferences in which they directed research, drafted proposed legislation, and prepared reports to the full Task Force. The following report reflects the recommendations of the Task Force as a whole. The appendices contain proposed legislation, policies, and commentary from the Task Force.

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Summary of Findings

The Nature and Scope of Elder Abuse Generally:

Elder abuse, neglect, and exploitation has been described at various times as "hiding in plain sight,"[i] a "hidden epidemic,"[ii] and a "silent crisis"[iii]—all despite the fact that "there are no official national statistics" on elder abuse.[iv] This has been attributed to a lack of uniform reporting systems in states, as well as a dearth of reporting by victims of such incidents and their caregivers.[v]

In 2004, it was estimated that there were 381,430 reports of elder abuse to adult protective services in the United States, or 8.33 reports for every 1,000 elders.[vi] What makes this number striking is that two studies have found that only about one out of fourteen[vii] or one out of every 23[viii] cases of elder abuse is actually reported to law enforcement or adult protective services. The "majority" of seniors so abused are those "who live in the community rather than in nursing homes or other senior living facilities;"[ix] indeed, approximately one in ten elders living in their homes experience abuse, neglect, or exploitation each year.[x] These findings are consistent with another national study finding that approximately 90% of abusers were known perpetrators, and 66% were adult children or spouses.[xi]

Elder Abuse & Neglect

- *Between 1 in 14 and 1 in 23 instances of abuse/neglect are reported.*
- *Up to a* ***million elders abused and*** *neglected annually in the U.S.*
- *Creates heightened risk of premature death and nursing home placement, depression, exacerbates existing conditions.*

Elder Financial Exploitation

- *1 in 25 financial exploitation instances reported*
- *Five million elder financial exploitation victims annually in the U.S.*
- *$2.6 billion in financial exploitation annually*

As for elder financial exploitation, a study estimated that reporting occurred in only one out of every 25 incidents, amounting to at least five million financial abuse victims each year.[xii] According to a separate 2009 study, the loss attributed to these incidents amounted to $2.6 billion annually in the United States.[xiii]

Beyond the financial costs of exploitation and obvious injuries caused by abuse and neglect, there are aggravating factors that make such acts against the elderly particularly harmful. It should be no surprise that elders' relative physical and mental frailty makes them susceptible to long-term harm from abuse. Indeed,

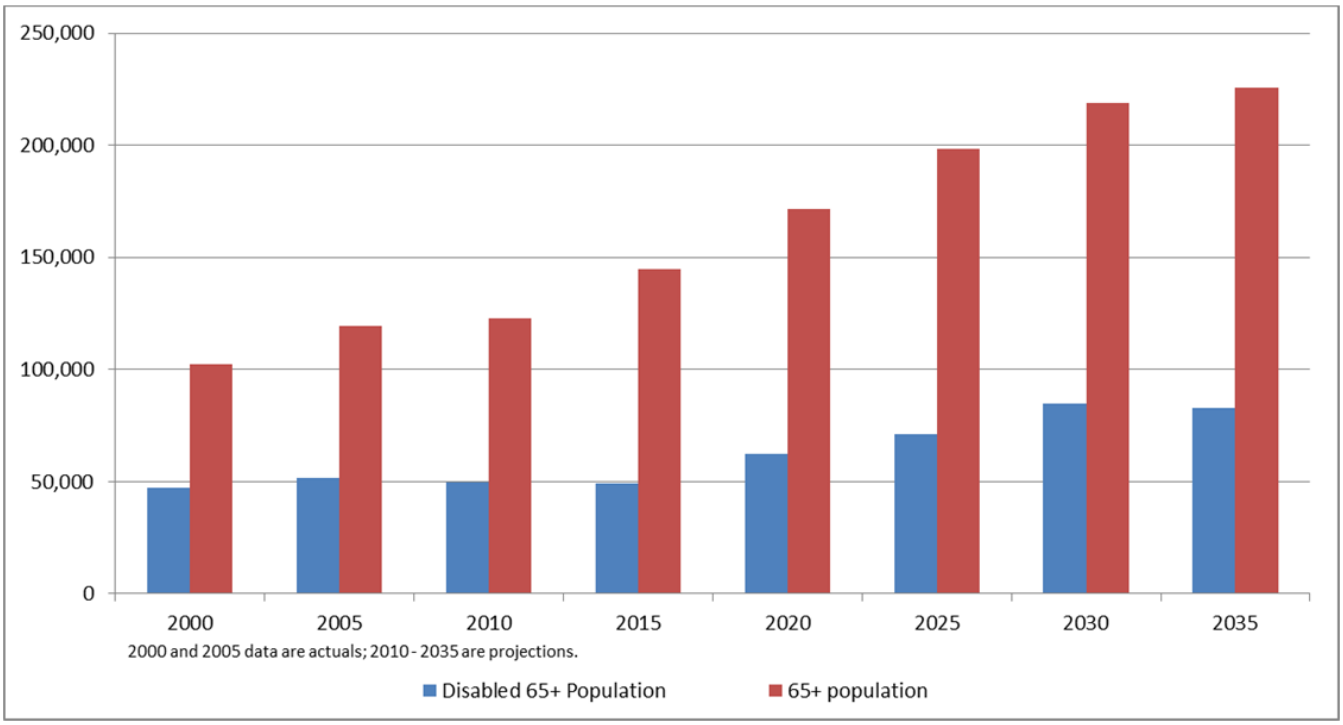
studies confirm that elder abuse victims face a five times greater risk of premature death, suffer poorer health and functioning, and experience a three-to-four times higher discharge rate to a nursing home after a hospital stay.[xiv]

Given the aging profile of this country's population, upward trends in elder abuse, neglect, and exploitation are likely to continue. South Dakota is no exception to this dynamic.

Scope of Challenges in South Dakota – A Matter of Demographics:

Because of reporting challenges, it was not possible to obtain a large amount of South Dakota-specific statistics on the prevalence of elder abuse. Some state statistics did, however, emerge. For instance, the Department of Social Services (DSS) reported receiving an annual average of 661 Adult Protective Service calls in the last five years. And according to the Unified Judicial System's (UJS) criminal charging information, in the past ten years, there were eight charges of theft by exploitation under SDCL 22-46-3, and ninety-two charges of adult abuse or neglect under SDCL 22-46-2. Considering the number of elders in South Dakota, the Task Force felt this number was exceedingly low.

Projections of South Dakota's Elderly and Disabled Population (2000 – 2035)



-From Abt Associates, *Evaluating Long-Term Care Options for South Dakota: Update*, 2015

According to a 2015 study prepared by Abt Associates for DSS's Division of Adult Services and Aging (DSS-ASA), the number of South Dakota citizens age 65 and older will increase nearly 84% from 2010 to 2035, from "approximately 103,000 to 226,000."[xv] Within this age cohort, the most vulnerable to elder abuse—disabled elders—will peak in 2030 at 85,000, increasing 71% from the 2010 Census total of about 33,000.[xvi] Put in different terms:

> By 2035, in all but 10 South Dakota counties elders will make up over 20 percent of the population. In 27 counties, elders will be over 40 percent of the local population. Even in the growing population centers, around Sioux Falls and Rapid City, elders will make up 29-30 percent of residents.[xvii]

While the most substantial population growth in the elder age cohort will occur in high population areas, areas of the state not surrounding Sioux Falls and Rapid City will still see their elder populations increase by between 25,000 and 50,000.[xviii] Resources in these rural areas, including specialized assistance from DSS-ASA, will be stretched even thinner. These resource concerns, coupled with national estimates and South Dakota's demographic outlook, indicate that elder abuse will have a profound impact on our state's future—an impact requiring a coordinated and planned response.

# of Adult Protective Service Calls to DSS-ASA

	Unduplicate Calls	Investigations
FY2011	561	450
FY2012	818	709
FY2013	602	424
FY2014	659	417
FY2015	665	446

*Calls are higher than investigations because DSS-ASA often receives multiple protective service calls on the same vulnerable adult investigated under a single protective service care plan.

**Whenever a case is opened, one of three outcomes occurs: (1) it is followed to resolution, (2) it is closed once a more appropriate party (such as law enforcement) takes over the investigation, or (3) it is closed as unsubstantiated.

Input from Stakeholders:

The Task Force received phone calls, e-mails, and in-person comments from stakeholders as well as concerned citizens whose elder family members were impacted by abuse, neglect, and exploitation. Their input is provided below.

Concerned citizens often related that existing legal processes—including powers of attorney, court-appointed guardians/conservators, and joint accounts—had been manipulated to exploit elders. Financial exploitation was the predominant form of elder abuse cited by these sources. Some individuals also

asserted that their elder parents were being isolated and emotionally abused by a close family or friend caregiver. Certain members of the public opined that financial institutions needed to play a more active role in reporting signs of financial exploitation.

Case workers and home care providers for elders related concerns about elder capacity and the proper time to intervene, particularly in cases of neglect and self-neglect. A consensus among care providers reflected a need for closer and more effective partnerships with law enforcement, particularly in rural communities. Some cited problems of law enforcement failure to follow up on reports in rural areas and in Reservation communities; a lack of particularized training for police on the signs of adult abuse, neglect, and exploitation; and the lack of prosecutor training to handle these often technical, domestic cases. One social worker suggested joint training on elder abuse and neglect for local Adult Services & Aging staff and law enforcement. These care providers universally asserted that instances of elder abuse, neglect, and exploitation were underreported. Multiple care providers indicated that the issue of elder abuse, in terms of public perception and law enforcement response, is where domestic abuse was thirty years ago.

Elder law attorneys and law enforcement noted that, in their experience, elder financial exploitation was the most widespread concern. However, law enforcement indicated that elder abuse and neglect was substantially underreported. One law enforcement officer with expertise on elder abuse raised the concern of ambiguity in our criminal statutes regarding who is culpable for neglecting an elder. Another cited the need to create a mechanism to quickly separate an in-home abuser or neglecter from an elder or vulnerable adult, and the need for prosecution and investigative specialists for elder abuse, neglect, and exploitation cases. An attorney that specializes in this area raised a concern regarding the use of binding arbitration in long-term care service agreements that keep cases of institutional elder abuse out of the courts. Elder lawyers and law enforcement noted that the often domestic nature of elder crimes makes reporting difficult, but law enforcement offered that they would arrest if they had probable cause, even if an elder parent did not want their abusive child arrested. An elder law attorney and sheriff both cited the need for greater cooperation and reporting from financial institutions to assist with investigating elder exploitation. Law enforcement also saw a need for Department of Social Services to increase disclosure of prior substantiated reports of abuse and neglect.

In contacting tribal agencies, there was a consensus on the need for additional resources to investigate abuse and to support elder service providers on

our Reservation communities. One coordinator for a Tribe's elder protection team reported that communication with DSS was generally good, but that a few cases involving non-Indians may have "fallen through the cracks" in rural areas. Those Tribes that were contacted and employed multidisciplinary elder protection teams cited their usefulness and ability to coordinate effectively.

The Task Force also heard from members of the health care, long-term care, and financial services industries. The health care and long-term care representatives noted their advances in specialized elder and dementia care, as well as the quality and caring motivations of their personnel. All three industries reported on the training their personnel generally receive regarding the signs and the need to report elder abuse and neglect (health care, long-term care) and financial exploitation (financial). Representatives of financial institutions noted that their businesses' ability to report and fully cooperate with law enforcement was limited by federal financial privacy laws.

Summary of Recommendations

After considering national data, state demographics, and stakeholder input, the Task Force offers the South Dakota Legislature the following sixteen recommendations, all but two being unanimous. The appendices to this report contain proposed legislation, policies and more detailed commentary.

1) **Criminalize "emotional and psychological abuse" of elders and adults with a disability.**
   South Dakota's existing criminal elder abuse statutes, SDCL 22-46-1 and 22-46-2, only criminalize assaults. Thirty-eight other states criminalize both assaults and emotional and psychological abuse. The Task Force unanimously recommends that our criminal statutes be amended to define emotional and psychological abuse of elders and adults with a disability and make it a Class 1 misdemeanor. See page 14 for draft proposed legislation and further commentary.

2) **Create a civil right of action that includes protection orders for abused, neglected, and exploited elders or adults with a disability.**
   Studies show that most elder abuse and neglect occurs in a home, rather than an institutional setting. The Task Force recommends adoption of a civil action with a remedy to physically protect elders and adults with a disability where they are domiciled, a remedy like that found in South Dakota's domestic protection order statutes. The proposed civil action, borrowed from Iowa, would also authorize courts to revoke powers of appointment granted by the elder to the offender, remove the offender from the elder's accounts, and revoke any other authority the offender was entitled to exercise over the elder by contract or law. See page 18 for draft proposed legislation.

3) **Recommend no action regarding the use of arbitration in long-term care contracts.**
   The Task Force heard comments from an attorney working in Elder Law that cases of elder abuse, neglect, and exploitation occurring in assisted living centers and nursing homes were not being reported because of binding arbitration agreements. The Task Force was told that such agreements are often embedded obscurely in long-term care contracts or they are signed with the understanding that agreeing to arbitration was a precondition for receiving services. Binding

arbitration can remove cases of abuse, neglect, and exploitation from the light of state court proceedings (and the full due process protections provided therein). Initially, a majority of the Task Force recommended legislation regulating arbitration agreements and prohibiting them as preconditions for admission to a long-term care facility. The intent was to provide greater assurance that arbitration was consented to by both parties. However, the Task Force subsequently became concerned that the proposal was unconstitutional under the Federal Supremacy Clause by operation of the Federal Arbitration Act. The Task Force also learned of policies favoring arbitration and of arguments suggesting that given our mandatory reporting laws, the proposed regulations would not impact institutional accountability. See page 28 for memos informing the Task Force's recommendation.

4) **Support DSS efforts to potentially revise the definition of "severe mental illness"—a basis for involuntary mental commitments—to exclude dementia patients, and to account for elders so committed.**
The Task Force was made aware of instances where elders with dementia, who were experiencing delirium due to medical conditions or who were disruptive and/or presented challenges to care providers, were being involuntarily committed to the Human Services Center in Yankton. The Task Force discovered that DSS also has been studying the issue. To avoid duplicative efforts, the Task Force supports DSS's continued work to determine whether it is possible to exclude dementia as a statutory basis for involuntary commitment. The Task Force also recommends that DSS ensure data transparency and task a particular entity or officer with measuring progress on this issue, thereby certifying that any policies have their intended effect.

5) **Recommend that South Dakota not create a central registry for abuse, neglect, and exploitation of elders or adults with a disability—much like the registry that exists for child abuse and neglect.**
Majority Position: South Dakota currently has a central registry for child abuse. At least twenty-two states also have a similar registry for elder and vulnerable adult abuse, neglect, and exploitation (AK, AZ, AR, CT, HI, ID, IA, KS, KY, MN, MS, MD, NE, NH, NJ, OK, TN, TX, UT, VT, WI, WY). These registries collect reports of substantiated abuse, neglect, and exploitation, and make that information available to licensing authorities and, in some cases, prospective employers and the public. The Task Force initially explored whether a central registry was necessary to capture individuals who abused elders, but were not criminally prosecuted. The Task Force engaged in extensive consultation with

DSS, which operates the central registry for children, and the Department of Health (DOH). The Task Force learned that both agencies employ existing registries in regulating elder care institutions and licensed home care providers. Ultimately, a majority of the Task Force determined that the cost of setting up and maintaining an expanded elder registry would outweigh the limited additional protection that could be provided by such a registry. DOH reassured the Task Force that its employment "red flag list," denoting people with a history of abuse or neglect, provided suitable protection with respect to institutions and licensed providers, and that its regulatory definition of abuse, neglect, and exploitation would encompass the Task Force's proposed definitions if the Legislature adopts the proposals. The Task Force's Education Committee also resolved to provide educational resources that would help consumers know the dangers that unlicensed providers may pose. See page 35 for discussion specifics.

Minority Position: The potential for abuse wherein persons found committing abuse move from position to position outside of employment in licensed and certified service programs warrants a substantiated abuse and offender central registry available to the public to ensure that abusers are not invited into positions to offend again.

6) **Increase the penalty for theft by exploitation of an elder or adult with a disability.**

Under current law, the punishment for elder financial exploitation is the same as theft—a misdemeanor or felony depending on the amount taken. *See* SDCL 22-46-3, 22-30A-17.1. According to UJS statistics, in the last five years, only approximately 20% of such cases involved felony exploitation. The Task Force believes that exploiting elders and adults with a disability warrants a more serious punishment: a minimum Class 6 felony, the same as elder abuse and neglect, while retaining higher punishments for aggravated theft depending on the amount taken. The Task Force believes this increase in punishment is warranted to deter individuals from preying on vulnerable populations. An increase would also make South Dakota's exploitation statute a more viable charging option for prosecutors in aggravated cases. See page 40 for draft proposed statutory language and accompanying commentary.

7) **Clarify the standards for reporting the abuse, neglect, or exploitation of an elder or adult with a disability.**

South Dakota has had a mandatory reporting statute for abuse, neglect, and exploitation of elders and adults with disabilities since 2011. However, unlike

most states, South Dakota lacks a description of what information should be conveyed in that report. Further, state law does not clearly indicate that financial exploitation is reportable by the public generally (and that good faith reporters of exploitation receive immunity). Additionally, the law does not designate a single authority with responsibility to receive all reports of abuse, neglect, and exploitation of vulnerable adults. Finally, the largest potential reporter of financial exploitation—financial institutions—have concerns with reporting suspected exploitive transactions in light of federal privacy laws. The Task Force recommends statutory revisions to address these concerns. See page 42 for draft proposed legislation and commentary thereon.

8) **Employ a new prosecutor and a new investigator in the Office of the Attorney General to specialize in prosecuting/investigating abuse, neglect, and exploitation of elders and adults with a disability.**
The Task Force received consistent public testimony on the lack of prosecution of financial exploitation and the difficulties of prosecuting the crime. The Task Force recommends that the Legislature appropriate funds for an attorney-specialist, within the Office of the Attorney General, whose role would be to prosecute or to assist state's attorneys in prosecuting the abuse, neglect, and financial exploitation of elders or adults with disabilities. The attorney-specialist would also serve as an educational resource and liaison for local and tribal law enforcement. The Task Force also recommends that the Legislature appropriate funds for an investigator specializing in these cases to assist the attorney in bringing criminal charges and providing education on this topic.

9) **Create a civil right of action for elders and adults with a disability to recover damages from exploitation.**
The civil right of action proposed in Recommendation 2 focuses on physical protection elders and adults with disabilities. Financial exploitation requires additional protections. Accordingly, the Task Force believes a special civil right of action should be available to allow vulnerable adults to recoup their stolen or embezzled property, and, in addition, permit them to recover attorney's fees. The proposed civil right of action is designed to permit victimized elders and adults with a disability—who often live on a diminished, fixed income—to obtain legal counsel that would otherwise be too costly to retain. It is also designed to dissuade others by authorizing punitive damages. It further authorizes a court to divest the offender of any probate or non-probate assets to which he or she would otherwise be entitled. See page 48 for draft proposed statutory language and added commentary.

10) **Create a form for establishing a durable power of attorney for financial decisions and enact legislation to better protect principals under durable powers of attorney.**

The Task Force heard from members of the public on the potential for elder abuse and exploitation resulting from durable powers of attorney. The task force recommends that education should be provided to the general public and legal practitioners that would include standard, understandable language for powers of attorney used in financial matters. For example, form language could provide specific information on what powers a principal can choose to authorize, as well as those duties an agent must follow. After initially drafting proposed form language to be included in a statute, the Task Force, in consultation with the State Bar of South Dakota, recommends that the State Bar draft a durable financial power of attorney form and make it available on its website and at its office. This is to ensure that legal experts will draft the form for general application. It also provides greater flexibility to make future improvements than if the forms are in statute. See page 52 for commentary.

The Task Force also recommends that the Legislature adopt revisions to SDCL 59-7-2.1, which are found on page 51. The revisions would require that a durable power of attorney, to be valid, must include the signature of the party signing over his/her power (the principal) before two adult witnesses. Further, the Task Force recommends that the State Bar's Real Property Committee look at whether South Dakota should adopt the Uniform Power of Attorney Act.

11) **Identify educational resources and suggest a public awareness campaign for elder abuse.**

The Education Committee is identifying educational resources and creating a strategy for disseminating information on elder abuse awareness that will complement the Task Force's recommendations. See page 54 for an overview of these resources, the timeline for dissemination, and the Committee's goals.

12) **Amend statutes to provide that the appointment of a guardian or conservator divests an agent under a power of attorney of his or her conflicting authority and prevent powers of attorney from being used to circumvent guardianships or conservatorships.**

Although powers of attorney provide needed flexibility, the accountability of agents under a durable power of attorney is often elusive after a principal becomes incapacitated. Further, conflicts develop when a guardian or conservator is appointed by a court after a principal with a durable power of

attorney becomes incapacitated. South Dakota law is unclear as to which fiduciary—the agent or the guardian/conservator—should be favored when this conflict develops. The Task Force recommends legislation providing that a guardian or conservator has authority over a conflicting power of attorney, because a guardian or conservator is statutorily accountable to the court, while a power of attorney is not. Further, the proposal clarifies that a protected person for whom a guardian or conservator is appointed may not thereafter authorize a power of attorney, as that power of attorney may be used to circumvent the authority of a court-authorized and monitored guardian or conservator. See page 56 for draft proposed legislation and commentary.

13) **Prepare educational resources and establish a statutory training requirement for all guardians and conservators.**
South Dakota is one of only ten states that lack any official or quasi-official education on guardianships and conservatorships. The Task Force recommends the creation of education resources by the State Bar of South Dakota. Anecdotal evidence reflects that many problems with guardianships and conservatorships are the result of a lack of information (and not malicious intent). Therefore, the Task Force recommends an educational curriculum be mandated for all guardians and conservators. The Task Force further recommends that the State Bar research and prepare a training curriculum that would become a statutory training requirement. That training curricula and requirement should balance the need to keep guardianships and conservatorships economical and user-friendly while ensuring training to support fiduciaries. See page 58 for recommendations and draft proposed legislation with commentary.

Special Writing: A member of the Task Force requested that whatever training requirement is established, the cost of the training should be disclosed plainly and up front.

14) **Encourage the court system to further monitor guardians and conservators using existing court electronic resources.**
The Task Force heard from members and stakeholders that guardian reports and conservator accountings could be better monitored by the UJS. Because reports and accountings are a significant method of overseeing the work of guardians and conservators, the Task Force felt that additional monitoring using internal court processes was needed. These specific recommendations and commentary thereon are found on page 60.

15) **Require background checks for all proposed guardians and conservators, and prohibit felons from serving as guardians or conservators unless a court finds special circumstances.**
At least sixteen states (AR, AZ, CA, CT, FL, GA, ID, MN, NE, NJ, ND, OH, OK, SC, VT, WV) require criminal background checks before a person may be appointed as a guardian, conservator, or guardian ad litem for a vulnerable adult. The Task Force recommends adoption of a statute requiring a criminal background check; a check of civil judgments for adult abuse, neglect, and exploitation; and that a report of these checks be presented to the court before a guardian or conservator may be appointed. See page 61 for draft legislation.

16) **Require sureties to notify the court and the protected person, minor, or estate if a guardian or conservator bond is not renewed.**
The Task Force noted that surety companies supplying bonds for guardians and conservators can provide an additional level of oversight and investigation before a guardian or conservator is appointed. A surety company will not bond a potential guardian or conservator that is seen as a risk to the obligee (the vulnerable adult). However, the Task Force ultimately rejected the idea that bonding should be presumptively mandated, noting that the additional cost of bonding would be borne by the protected person, the minor, or his/her estate. Further, the Task Force noted that requiring background checks of prospective guardians and conservators (Recommendation 15) would accomplish many of the same goals as imposing a presumptive bonding requirement.

Ultimately, after taking public testimony, the only major deficiency discovered by the Task Force regarding bonding concerned the lack of notice when bonds lapse. Accordingly, the Task Force recommends amending statute to require that sureties notify the court and the protected person, minor, or estate when a court-ordered bond is not renewed. See the draft on page 64.

Endnotes

i. "Elder Abuse: Hiding in Plain Sight," Georgia Dep't of Human Servs., Div. of Aging Servs., *available at* http://www.gpb.org/elder-abuse (last accessed Sept. 17, 2015).

ii. "Fighting Back Against the Hidden Epidemic of Elder Abuse," U. S. Dep't of Justice (June 14, 2012), *available at* http://www.justice.gov/opa/blog/fighting-back-against-hidden-epidemic-elder-abuse.

iii. "World Elder Abuse Awareness Day, Nebraska Toolkit," Neb. Dep't of Health & Human Servs., *available at* http://dhhs.ne.gov/children_family_services/Elder%20Abuse/Tool%20Kit.pdf (last accessed Sept. 17, 2015).

iv. "Elder Abuse Prevalence and Incidence," Nat'l Ctr. on Elder Abuse (2005), *available at* http://www.ncea.aoa.gov/resources/publication/docs/finalstatistics050331.pdf.

v. *Id.*

vi. Nat'l Ctr. on Elder Abuse, *The 2004 Survey of State Adult Protective Services: Abuse of Adults 18 Years of Age and Older* 19-20, Mar. 2007, *available at* http://www.ncea.aoa.gov/Resources/Publication/docs/APS_2004NCEASurvey.pdf.

vii. Nat'l Ctr. on Elder Abuse, Statistics/Data (citing National Research Council. (2003) Elder mistreatment: Abuse, neglect and exploitation in an aging America. Washington, D.C.: The National Academies Press), http://www.ncea.aoa.gov/Library/Data/index.aspx (last access Sept. 17, 2015).

viii. Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, New York City Department for the Aging. Under the Radar: New York State Elder Abuse Prevalence Study. Self-reported prevalence and documented case surveys [Final Report] 2011, *available at:* http://www.ocfs.state.ny.us/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf

ix. U.S. Dep't of Justice, Elder Justice Initiative, http://www.justice.gov/elderjustice/research/ (last accessed Sept. 17, 2015).

x. Nat'l Clearinghouse on Abuse in Later Life, "An Overview of Elder Abuse: A Growing Problem" (citing Acierno et al., 2010; Beach et al., 2010; Lifespan of Greater Rochester et al. (*supra* note viii)), *available at* http://www.ncall.us/sites/ncall.us/files/resources/1.%20Overview.pdf.

xi. Nat'l Ctr. on Elder Abuse & Westat, Inc., *The National Elder Abuse Incidence Study* 1 (Sept. 1998), *available at* http://aoa.gov/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf.

xii. "Elder Abuse Prevalence," *supra* note iv. (citing John Wasik, "The Fleecing of America's Elderly," *Consumers Digest*, Mar./Apr. 2000, at 78-79).

xiii. MetLife Mature Market Institute, Nat'l Cmte. for the Prevention of Elder Abuse, & Ctr. for Gerontology at Va. Polytechnic Inst., *Broken Trust: Elders, Family, and Finances: A study on Elder Financial Abuse Prevention* 5, Mar. 2009, *available at* https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders- family-finances.pdf.

xiv. Georgia J. Anetzberger, "An Update on the Nature and Scope of Elder Abuse," Am. Soc'y on Aging (Oct. 1, 2012) (citing Dong et al., 2009/2011; Baker et al., 2009; MetLife MMI 2009/2011(*supra* note xiii)), http://www.asaging.org/blog/update-nature-and-scope-elder-abuse

xv. Abt Assocs., Evaluating Long-Term Care Options for South Dakota: Update 8 (2015), *available at* http://dss.sd.gov/docs/news/reports/finalreportsdltc.pdf.

xvi. *Id.* at 9.

xvii. *Id.* at 10.

xviii. *Id.* at 9, 16.

Proposed Legislation and Policy Recommendations

FOR AN ACT ENTITLED, An Act to adopt the Elder Abuse Task Force's statutory recommendations in order to protect South Dakota seniors and adults with disabilities from abuse, neglect, and exploitation.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Recommendation 1: Criminalize "emotional and psychological abuse" of elders and adults with a disability.

A. Definition of "Emotional and Psychological Abuse"

Section 1. That § 22-46-1 be amended to read as follows:

22-46-1. Terms used in this chapter mean:

(1) ~~"Abuse," physical harm, bodily injury, or attempt to cause physical harm or injury, or the infliction of fear of imminent physical harm or bodily injury on an elder or a disabled adult;~~

Commentary – This definition was renamed "physical abuse" (found below, (7)) to permit the inclusion of "emotional and psychological abuse" as elder abuse (also found below, (4)).

(2) "Adult with a disability," a person eighteen years of age or older who ~~suffers from~~ has a condition of intellectual disability, infirmities of aging as manifested by organic brain damage, advanced age, or other physical dysfunctioning to the extent that the person is unable to protect himself or herself or provide for his or her own care;

Commentary – This amendment is suggested to eliminate the requirement that an adult with a disability must prove to a court that they "suffer" from their condition.

(2) "Caretaker," a person or entity who is in a position of trust to an elder or adult with a disability, or who is responsible for the health or welfare of an elder or adult with a disability, and who assumed the position of trust or responsibility voluntarily, by contract, by receipt of payment, or by order of the court;

Commentary – We received feedback from law enforcement who work on elder abuse and neglect cases that a person who becomes criminally liable for neglect was not currently well defined in statute. This borrows language from the theft by exploitation statute, SDCL 22-46-3, while adding that a caretaking duty can arise by volunteering. At least ten other states allow criminal neglect to be based on the voluntary assumption of the duty of care: CA, IA, MA, MO, NV, NC, OH, TN, VT, WV.

(3) "Elder," a person sixty-five years of age or older;

(4) "Emotional and psychological abuse," a caretaker's repeated or gross infliction of:

(a) Sexually exploitative acts involving obscene nudity that are harmful to a nonconsenting elder or adult with a disability;

(b) Unreasonable confinement;

(c) Harm or damage or destruction of the property of an elder or adult with a disability, including harm to or destruction of pets; or

(d) Ridiculing or demeaning conduct, derogatory remarks, verbal harassment, or threats to inflict physical or emotional and psychological abuse, directed at an elder or adult with a disability;

Commentary— This is a new provision to criminalize emotional and psychological abuse. "Unreasonable confinement" is a phrase borrowed from N.H. Rev. Stat. § 161-F:43. Nevada Rev. Stat. § 200.5092 is the basis for references to property destruction. Subpart (d) derives from Arizona and Delaware criminal statutes. Ariz. Rev. Stat. § 13-3623(F)(3), 31 Del. Code §§ 3902(1)(b). Each of these definitions of emotional and psychological abuse

involves at least one unique element not found elsewhere in South Dakota's criminal code.

(5) "Exploitation," the wrongful taking or exercising of control over property of an elder or ~~a disabled~~ adult with a disability with intent to defraud the elder or ~~disabled~~ adult with a disability; and

Commentary—Statutory compilations try to use person-first descriptions of individuals with disabilities. While these suggested revisions do not capture all of the instances that "disabled adult" is used, it is suggested to make similar changes throughout the chapter.

~~(5)~~(6) "Neglect," harm to ~~an elder's or a disabled adult's~~ the health or welfare of an elder or an adult with a disability, without reasonable medical justification, caused by a caretaker, within the means available for the elder or ~~disabled~~ adult with a disability, including the failure to provide adequate food, clothing, shelter, or medical care;

Commentary—These revisions incorporate the revised definition of "caretaker" above and thereby help to better define who becomes criminally responsible for neglect of an elder or an adult with a disability.

(7) "Physical abuse," physical harm, bodily injury, attempt to cause physical harm or injury, or fear of imminent physical harm or bodily injury.

B. Abuse and Neglect Punishment Statute

Section 2. That § 22-46-2 be amended to read as follows:

22-46-2. Any person who physically abuses or neglects an elder or ~~a disabled adult~~ adult with a disability in a manner which does not constitute aggravated assault is guilty of a Class 6 felony.

Any person who emotionally or psychologically abuses an elder or adult with a disability is guilty of a Class 1 misdemeanor.

Commentary—The Task Force initially found two options two pursue on this issue and chose Option 2. Option 1 would have made the punishment for emotional and psychological abuse the same as physical abuse and neglect—a Class 6 felony. Option 2, suggested above, would authorize punishment for emotional and psychological abuse less severely (a Class 1 misdemeanor). Based on staff research, a Class 6 felony is in the middle range of punishments for emotional and psychological elder abuse nationwide. The Task Force recommends a Class 1 misdemeanor because the potential for a penitentiary sentence may be too harsh in some cases involving emotional or psychological abuse.

Recommendation 2: Create a civil right of action that includes protection orders for abused, neglected, and exploited elders or adults with a disability.

Section 3. Terms used in sections 3 to 20, inclusive, of this Act mean, unless the context otherwise requires:

(1) "Attorney in fact," an agent under a power of attorney pursuant to chapter 59-2 or an attorney in fact under a durable power of attorney pursuant to § 59-7-2.1;

(2) "Caretaker," a related or nonrelated person who has the responsibility for the health or welfare of a vulnerable adult as a result of assuming the responsibility voluntarily, by contract, by receipt of payment for care, or by order of the court;

(3) "Conservator," as defined in subdivision 29A-5-102(2);

(4) "Vulnerable adult abuse," any of the following:

(a) Physicalabuse as defined in section 1 of this Act;

(b) Emotionaland psychologicalabuse as defined in section 1 of this Act;

(c) Neglect as defined in section 1 of this Act and § 22-46-1.1; or

(d) Financial exploitation;

(5) "Family or household member," a spouse, a person cohabiting with the vulnerable adult, a parent, or a person related to the vulnerable adult by consanguinity or affinity, but does not include children of the vulnerable adult who are less than eighteen years of age;

(6) "Fiduciary," a person or entity with the legal responsibility to make decisions on behalf of and for the benefit of a vulnerable adult and to act in good faith and with fairness. The term, fiduciary, includes an attorney in fact, a guardian, or a

conservator;

(7) "Financialexploitation," exploitationas defined in section 1 of this Act when committed by a person who stands in a position of trust or confidence;

(8) "Guardian," as defined in subdivision 29A-5-102(4);

(9) "Peace officer," as defined in subdivision 23A-45-9(13);

(10) "Petitioner," a vulnerable adult who files a petition pursuant to sections 3 to 20, inclusive, of this Act, and includes a substitute petitioner who files a petition on behalf of a vulnerable adult pursuant to sections 3 to 20, inclusive, of this Act;

(11) "Present danger of vulnerable adult abuse," a situation in which the respondent has recently threatened the vulnerable adult with initial or additional abuse or neglect or the potential for misappropriation, misuse, or removal of the funds, benefits, property, resources, belongings, or assets of the vulnerable adult combined with reasonable grounds to believe that abuse, neglect, or exploitation is likely to occur;

(12) "Pro se," a person proceeding on the person's own behalf without legal representation;

(13) "Stands in a position of trust or confidence," the person has any of the following relationships relative to the vulnerable adult:

(a) Is a parent, spouse, adult child, or other relative by consanguinity or affinity of the vulnerable adult;

(b) Is a caretaker for the vulnerableadult;

(c) Is a person who is in a confidential relationship with the vulnerable adult. A confidential relationship does not include a legal, fiduciary, or ordinary commercial or transactional relationship the vulnerable adult may have with

a bank incorporated pursuant to the provisions of any state or federal law; any savings and loan association or savings bank incorporated pursuant to the provisions of any state or federal law; any credit union organized pursuant to the provisions of any state or federal law; any attorney licensed to practice law in this state; or any agent, agency, or company regulated under title 58 or chapter 36-21A;

(14) "Substitute petitioner," a family or household member, guardian, conservator, attorney in fact, or guardian ad litem for a vulnerable adult, or other interested person who files a petition pursuant to sections 3 to 20, inclusive, of this Act;

(15) "Vulnerable adult," a person sixty-five years of age or older who is unable to protect himself or herself from abuse as a result of age or a mental or physical condition, or an adult with a disability as defined in Section 1 of this Act.

Commentary—This section is modeled after Iowa Code §235F.1. The definitions of "caretaker", "abuse" and "neglect" correspond to the definitions proposed in the criminal elder and adult with a disability abuse and neglect chapter, SDCL 22-46. This language also deviates from Iowa Code by providing relief to adults with a disability.

Section 4. A vulnerable adult or a substitute petitioner may seek relief from vulnerable adult abuse by filing a petition and affidavit in the circuit court or in a magistrate court with a magistrate judge presiding. Venue is where either party resides. The petition and affidavit shall include all of the following:

(1) The name of the vulnerable adult and the name and address of the vulnerable adult's attorney, if any. If the vulnerable adult is proceeding pro se, the petition shall include a mailing address for the vulnerable adult;

(2) The name of the substitute petitioner if the petition is being filed on behalf of a vulnerable adult, and the name and address of the attorney of the substitute petitioner. If the substitute petitioner is proceeding pro se, the petition shall include a mailing address for the substitute petitioner;

(3) The name and address, if known, of the respondent;

(4) The relationship of the vulnerable adult to the respondent;

(5) The nature of the alleged vulnerable adult abuse, including specific facts and circumstances of the abuse;

(6) The name and age of any other individual whose welfare may be affected; and

(7) The desired relief, including a request for temporary or emergency orders.

A petition for relief may be made whether or not there is a pending lawsuit, complaint, petition, or other action between the parties. However, if there is any other lawsuit, complaint, petition, or other action pending between the parties, any new petition made pursuant to this section shall be made to the judge previously assigned to the pending lawsuit, petition, or other action, unless good cause is shown for the assignment of a different judge.

If a petition for a protection order alleging the existence of vulnerable adult abuse is filed with the court pursuant to this section and, if the court, upon an initial review, determines that the allegations do not support the existence of vulnerable adult abuse, but that the allegations do support the existence of stalking or physical injury pursuant to § 22-19A-8 or domestic abuse pursuant to § 25-10-3, the court, in its discretion, may hear and act upon the petition as though the petition had been filed under § 22-19A-8 or § 25-10-3 and subject to the provisions of the respective chapters.

Section 5. If an affidavit filed with a petition under Section 4 of this Act alleges that the vulnerable adult is in present danger of vulnerable adult abuse before an adverse party or his or

her attorney can be heard in opposition, the court may grant an ex parte temporary protection order pending a full hearing and grant relief as the court deems proper, including an order:

(1) Restraining any person from committing vulnerable adult abuse;

(2) Excluding any person from the dwelling or the residence of the vulnerable adult..

Section 6. If a substitute petitioner files a petition pursuant to section 4 of this Act on behalf of a vulnerable adult, the vulnerable adult retains the right to all of the following:

(1) To contact and retain counsel;

(2) To have access to personal records;

(3) To file objections to the protection order;

(4) To request a hearing on the petition; and

(5) To present evidence and cross-examine witnesses at the hearing.

Section 7. By July 1, 2016, the Unified Judicial System shall prescribe standard forms to be used by a vulnerable adult or substitute petitioner seeking a protection order by proceeding pro se in an action pursuant to sections 3 to 20, inclusive, of this Act.

The clerk of the circuit court shall furnish the required forms to any person seeking a protection order through pro se proceedings pursuant to sections 3 to 20, inclusive, of this Act.

Commentary—The South Dakota Unified Judicial System already supplies pro se verified petitions for protection orders in domestic and stalking/ physical injury situations, per South Dakota law. See SDCL 25-10-3 (domestic), 22-19A-8 (stalking).

Section 8. Pursuant to § 15-6-17(c), the court may on its own motion or on the motion of a party appoint a guardian ad litem for a vulnerable adult if justice requires. The vulnerable adult's attorney may not also serve as the guardian ad litem.

Commentary—South Dakota law currently provides that "[t]he court shall

appoint a guardian ad litem for a minor or incompetent person not otherwise represented in an action or shall make such other order as it deems proper for the protection of the minor or incompetent person and may make such appointment notwithstanding an appearance by a guardian or conservator." SDCL 15-6-17(c).

Section 9. Upon receipt of the petition, if sufficient grounds are alleged for relief, the court shall order a hearing which shall be held not later than thirty days from the date of the order unless the court grants a continuance for good cause. Personal service of the petition, affidavit, and notice for hearing shall be made on the respondent not less than five days prior to the hearing .

Upon application of a party, the court shall issue subpoenas requiring attendance and testimony of witnesses and production of papers.

The court shall exercise its discretion in a manner that protects the vulnerable adult from traumatic confrontation with the respondent.

Hearings shall be recorded.

Upon application, notice to all parties, and hearing, the court may modify the terms of an existing protection order.

Section 10. An ex parte temporary protection order is effective for a period of thirty days except as provided in section 11 of this Act unless the court grants a continuance for good cause. No continuance may exceed thirty days. If a continuance is granted, the court by order shall extend the ex parte temporary protection order until the rescheduled hearing date. The respondent shall be personally served with a copy of the ex parte order along with a copy of the petition, affidavit, and notice of the date set for the hearing. The ex parte order shall be served without delay under the circumstances of the case including service of the ex parte order on a Sunday or holiday. The law enforcement agency serving the order shall notify the petitioner by

telephone or written correspondence when the order is served if the petitioner has provided to the law enforcement agency either a telephone number or address, or both, where the petitioner may be contacted. The law enforcement agency and any officer of the law enforcement agency is immune from civil and criminal liability if the agency or the officer makes a good faith attempt to notify the petitioner in a manner consistent with the provisions of this section.

Section 11. If an ex parte temporary protection order is in effect and the court issues a protection order pursuant to sections 13 through 20, inclusive, of this Act, the ex parte temporary protection order remains effective until the order issued pursuant to sections 13 through 20, inclusive, of this Act is served on the respondent.

Section 12. The showing required pursuant to section 13 of this Act may be made by any of the following:

(1) The vulnerable adult;

(2) The guardian, conservator, attorney in fact, or guardian ad litem of the vulnerable adult;

(3) A witness to the vulnerable adult abuse; or

(4) An adult protective services worker who has conducted an investigation.

Section 13. Upon a finding by a preponderance of the evidence that vulnerable adult abuse has taken place, the court may order any of the following:

(1) That the respondent be required to move from the residence of the vulnerable adult if both the vulnerable adult and the respondent are titleholders or contract holders of record of the real property, are named as tenants in the rental agreement concerning the use and occupancy of the dwelling unit, are living in the same residence, or are married to each other;

(2) That the respondent provide suitable alternative housing for the vulnerable adult;

(3) That a peace officer accompany the party who is leaving or has left the party's residence to remove essential personal effects of the party;

(4) That the respondent be restrained from vulnerable adult abuse;

(5) That the respondent be restrained from entering or attempting to enter on any premise when it appears to the court that restraint is necessary to prevent the respondent from committing vulnerable adult abuse;

(6) That the respondent be restrained from exercising any powers on behalf of the vulnerable adult through a court-appointed guardian, conservator, or guardian ad litem, an attorney in fact, or another third party;

(7) In addition to the relief provided in section 14 of this Act, other relief that the court considers necessary to provide for the safety and welfare of the vulnerable adult.

Any relief granted by the order for protection shall be for a fixed period and may not exceed five years.

Section 14. If the court finds that the vulnerable adult has been the victim of financial exploitation, the court may order the relief the court considers necessary to prevent or remedy the financial exploitation, including any of the following:

(1) Directing the respondent to refrain from exercising control over the funds, benefits, property, resources, belongings, or assets of the vulnerable adult;

(2) Requiring the respondent to return custody or control of the funds, benefits, property, resources, belongings, or assets to the vulnerable adult;

(3) Requiring the respondent to follow the instructions of the guardian, conservator, or attorney in fact of the vulnerable adult;

(4) Prohibiting the respondent from transferring the funds, benefits, property, resources, belongings, or assets of the vulnerable adult to any person other than the vulnerable adult.

Commentary—The equivalent provision for domestic protection orders is SDCL 25-10-5. Note that the Financial Exploitation Committee suggested a civil cause of action specific to elder and vulnerable adult financial exploitation that incorporates by reference the remedies provided in Section 14. That "exploitation" cause of action is found in Sections 28 through 33 on pages 48 to 51.

Section 15. The court may not use an order issued pursuant to sections 13 to 20, inclusive, of this Act, to do any of the following:

(1) To allow any person other than the vulnerable adult to assume responsibility for the funds, benefits, property, resources, belongings, or assets of the vulnerable adult; or

(2) For relief that is more appropriately obtained in a proceeding filed pursuant to chapter 29A-5 including giving control and management of the funds, benefits, property, resources, belongings, or assets of the vulnerable adult to a conservator for any purpose other than the relief granted pursuant to section 14 of this Act.

Section 16. A protection order shall be for a fixed period of time not to exceed five years. The court may amend or extend an order at any time upon a petition filed by either party and after notice and a hearing. The court may extend an order if the court, after a hearing at which the respondent has the opportunity to be heard, finds that the respondent continues to pose a threat to the safety of the vulnerable adult, a person residing with the vulnerable adult, or a member of the vulnerable adult's immediate family, or continues to present a risk of financial exploitation of the vulnerable adult. The number of extensions that the court may grant is not limited.

Section 17. The court may order that the respondent pay the attorney's fees and court costs of the vulnerable adult and substitute petitioner.

Commentary—The proposalwould beuniquefor protection ordersin South Dakota law as the court is authorized to order respondent to pay petitioner's/substitute petitioner's attorney's fees and court costs.

Section 18. An order pursuant to sections 3 to 20, inclusive, of this Act, does not affect title to real property.

Section 19. The petitioner may deliver an order within twenty-four hours to the local law enforcement agency having jurisdiction over the residence of the vulnerable adult. Each law enforcement agency shall make available to other law enforcement officers information as to the existence and status of any order for protection issued pursuant to sections 3 to 20, inclusive, of this Act.

Section 20. The petitioner's right to relief under sections 3 to 20, inclusive, of this Act, is not affected by the vulnerable adult leaving home to avoid vulnerable adult abuse.

Recommendation 3: Recommend no action regarding the use of arbitration in long-term care contracts.

Commentary—the following memoranda are part of the basis for the Task Force's decision to decline recommending legislation regulating arbitration in long-term care agreements.

Long-Term Care Arbitration Agreement Research

TO: Justice Steven Zinter

FROM: Justin Goetz

DATE: November 6, 2015

RE: Whether the Federal Arbitration Act Preempts the Proposed Statutory Language in Draft Recommendation 3

Background Research:

Section 2 of the Federal Arbitration Act (FAA), 9 U.S.C. § 2, provides, in relevant part:

> A written provision in . . . a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction . . . shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

The United States Supreme Court has construed this language as showing that "Congress declared a national policy favoring arbitration and withdrew the power of the states to require a judicial forum for the resolution of claims which the contracting parties agreed to resolve by arbitration." *Southland Corp. v. Keating*, 465 U.S. 1, 10, 104 S. Ct. 852, 858, 79 L. Ed. 2d 1 (1984). In other words, "when state law prohibits outright the arbitration of a particular type of claim, the analysis is straightforward: The conflicting rule is displaced by the FAA." *Marmet Health Care Ctr., Inc. v. Brown*,___U.S.___, 132 S. Ct. 1201, 1203, 182 L. Ed. 2d

42 (quoting *AT&T Mobility LLC v. Concepcion*, 563 U.S.___, 131 S. Ct. 1740, 1747, 179 L. Ed. 2d 742 (2011)).

<u>Original Majority Position</u>:

The Task Force initially explored if it was possible to prevent long-term care service providers from requiring elders sign binding arbitration clauses in order to receive services. Binding, pre-dispute arbitration generally prevents an elder from being able to bring contract and tort claims arising out of their long-term care services in a court of law. In so doing, the elder forgoes important rights, including the expansive civil procedure and discovery rights provided in our courts, a right to jury trial, and other key protections. Given the nature of these admissions agreements and the often traumatic circumstances that surround their execution, a binding arbitration clause could make an admissions agreement an unconscionable adhesion contract, or an unconscionable "standard-form contract prepared by one party, to be signed by another party in a weaker position . . . who adheres to the contract with little choice about the terms." Black's Law Dictionary (10th ed. 2014). Put another way, the elder could be forced to sign the arbitration agreement against his or her will in order to receive long-term care services. In a rural state like South Dakota—with potentially one long-term care provider within a hundred miles of the only home, friends, and family an elder has known—this is a real concern.

This concern is reflected in the Center for Medicare and Medicaid Services recently issuing a proposed rule that would prohibit long-term care facilities receiving Medicare and Medicaid funds from conditioning service on signing arbitration agreements. *See* 80 Fed. Reg. 42167 (proposed July 16, 2015) (to be codified at 42 C.F.R. Pts. 405, 431, 447, 482, 483, 485, and 488). It is also reflected in bills introduced in Congress, which would clarify that the FAA "was intended to apply to disputes between commercial entities of generally similar sophistication and bargaining power" and not to "consumer disputes and employment disputes" wherein "consumers and employees have little or no meaningful choice whether to submit their claims to arbitration" and "are not even aware that they have given up their rights." *See* S. 1133, 114th Cong., 1st Sess. (2015); H.R. 2087, 114th Cong., 1st Sess. (2015).

This concern is further magnified by the U.S. Supreme Court's own findings. In *Stolt-Nielsen S.A. v. Animal Feeds International Corp.*, 559 U.S. 662, 680, 130 S. Ct. 1758, 1773, 176 L. Ed. 2d 605, the Court held that as a matter of "fundamental importance," the FAA establishes "the basic precept that arbitration 'is a matter of

consent, not coercion[.]'" *Id.* (quoting *Volt Info. Sciences, Inc. v. Bd. of Trustees of Leland Stanford Junior Univ.*, 489 U.S. 468, 479, 109 S. Ct. 1248, 103 L. Ed. 2d 488 (1989)). If, indeed, consent is the key, then statute may be needed to ensure that the party in a long-term care transaction with far less sophistication and bargaining power actually consented to the arbitration agreement and was not forced by an unconscionable "take-it-or-leave-it" situation.

The Task Force initially considered statutory language for this purpose. The Task Force then determined that the statute appeared to enshrine the existing practice of South Dakota long-term care providers, as indicated by the membership survey of the South Dakota Health Care Association presented to the Task Force. The survey indicated no responding members condition admission on signing an arbitration agreement. This statute would then make that practice clear to prospective admittees, with the intention of ensuring their knowing and voluntary consent.

Why the Original Majority Position is Likely Not Legally Viable:

Yet, as was brought out by Mark Deak at the 10/29/2015 Elder Abuse Task Force meeting, the United States Supreme Court has rejected the application of statute akin to what the Task Force was considering. I believe that holding presents an insurmountable obstacle, despite the initial intentions of the Majority, and it forms the basis of this recommendation.

In *Doctor's Associates, Inc. v. Casarotto*, 517 U.S. 681, 116 S. Ct. 1652, 134 L. Ed. 2d 902 (1996), the Court dealt with a statute from Montana requiring a notice that a contract contained an arbitration clause to be displayed prominently on the first page of the contract or the arbitration clause would be void. *See id.* at 684, 116 S. Ct. at 1654 (citing Mont. Code § 27-5-114(4)). The Montana Supreme Court had upheld this provision on the grounds that it "did not undermine the goals and policies of the FAA" and that it in fact upheld the FAA's fundamental precept of consent by seeking to ensure arbitration was entered into knowingly and voluntarily. *Id. at* 685, 116 S. Ct. at 1655; *see also Casarotto v. Lombardi*, 886 P.2d 931, 938-39 (Mont. 1994), *overruled by Doctor's Assocs., supra*. The Court rejected this rationale (and, by extension, the rationale of the Majority) by expanding on the concepts outlined in the "Background Research" section above:

> By enacting § 2, we have several times said, Congress precluded States from singling out arbitration provisions for suspect

> status, requiring instead that such provisions be placed "upon the same footing as other contracts." Montana's § 27-5-114(4) directly conflicts with § 2 of the FAA because the State's law conditions the enforceability of arbitration agreements on compliance with a special notice requirement not applicable to contracts generally. The FAA thus displaces the Montana statute with respect to arbitration agreements covered by the Act.

Id. at 687, 116 S. Ct. at 1656 (citation omitted). Notably, the Court chose to refute the "fundamental precept of consent" rationale given by the Montana Supreme Court in an indirect way. It began by asserting that by the plain language of § 2 of the FAA, Congress expressly prohibits States and the courts from "threshold limitations placed specifically and solely on arbitration provisions." *See id.* at 688.

The Court reasserted that § 2 instead allows the invalidation of arbitration clauses on the same grounds as contracts generally. *See id.* ("Section 2 'mandates the enforcement of arbitration agreements . . . save upon such grounds as exist at law or in equity for the revocation of any contract.'" (citations omitted)). In that way, the Court appears to assert that the "fundamental precept" of consent in executing arbitration agreements can and must be determined on a case-by-case basis by courts applying traditional contract law principles (such as unconscionability) to the specific facts of the case, and that per § 2 of the FAA, arbitration clauses cannot be disfavored in a blanket fashion by statute, or for that matter, by a court. *See id.* at 687 n.3, 116 S. Ct. at 1656 n.3 ("It bears reiteration, however, that a court may not 'rely on the uniqueness of an agreement to arbitrate as a basis for a state-law holding that enforcement would be unconscionable, for this would enable the court to effect what . . . the state legislature cannot.'" (omission in original) (quoting *Perry v. Thomas*, 482 U.S. 482, 492 n.9, 107 S. Ct. 2520, 2527 n.9, 96 L. Ed. 2d 426 (1987))).

<u>Recommendation</u>:

Because the United States Supreme Court's holding in *Doctor's Associates* rejected both the type of arbitration-targeting notice statute initially proposed in the Task Force's Draft Recommendation 3, and the rationale employed by the Majority (initially) in support of the proposal, I recommend that "No Action Be Taken."

November 10, 2015

Justice Steven L. Zinter, Chair
South Dakota Elder Abuse Task Force

Re: Position Regarding Use Arbitration Agreements

Dear Justice Zinter:

I have been privileged to serve as a member of the South Dakota Elder Abuse Task Force (EATF). I appreciate the opportunity to submit this dissenting position regarding recommendation 3 of the *Final Report and Recommendations* (draft). Please consider the following points:

1. Dispute resolution by arbitration is generally quicker, more collaborative, and less expensive than going through the court system. Arbitration has been used successfully widely in healthcare, including by hospitals and physician practices, and is generally felt to protect the interests of patients, providers, and court systems alike. Arbitration provides an alternate forum for legal claims to be decided. There is no compelling reason to single out arbitration agreements used by long term care providers for unique and conditional regulation.

2. Impact on the Court System. Marginalization of arbitration agreements will have the impact of shifting burden to court systems. This is not in the best interests of residents, families, the long term care industry, or the court system. Further, the proposed 30 day "cooling off" period is not applicable to any other contracts, and it is of dubious value to create unique conditions that apply only to arbitration agreements for nursing homes or assisted living facilities.

3. Accountability. An arbitration agreement does not impact or in any way preclude the ability of the federal government or the state to cite facilities for

violation of regulatory requirements. Residents and their families are not prohibited from reporting and/or discussing any concerns that they have with the Ombudsmen, other government officials, or the public. In fact, healthcare facilities are mandatory reporters and must report abuse and neglect. The state survey process also reinforces this transparency.

I respectfully request that the Task Force reconsider its proposed recommendation regarding conditions placed on the use of arbitration agreements.

Thank you for allowing me the opportunity to share this opinion.

Sincerely,

Dr. Victoria Walker
Task Force Member

c. Task Force Members
Justin Goetz

Recommendation 4: Support DSS efforts to potentially revise the definition of "severe mental illness"—a basis for involuntary mental commitments—to exclude dementia patients, and to account for elders so committed.

Commentary—The Task Force was made aware of instances where elders with dementia, who were experiencing delirium due to medical conditions or who were disruptive and/or presented challenges to care providers, were being involuntarily committed to the Human Services Center in Yankton. The Task Force discovered that DSS also has been studying the issue. To avoid duplicative efforts, the Task Force supports DSS's continued work to determine whether it is possible to exclude dementia as a statutory basis for involuntary commitment. The Task Force also recommends that DSS ensure data transparency and task a particular entity or officer with measuring progress on this issue, thereby certifying that any policies have their intended effect.

Recommendation 5: Recommend that South Dakota not create a central registry for abuse, neglect, and exploitation of elders or adults with a disability—much like the registry that exists for child abuse and neglect.

A. Majority Report:

Summary of DOH/DSS Position on a Central Registry Concept

S.D. Elder Abuse Task Force

Existing Monitoring and Reporting: Our current statutory and regulatory framework provides active monitoring of all licensed healthcare personnel—from physicians, nurses, and physician assistants, to physical therapists, nutritionists and certified nursing assistants. These existing functions are akin to a central registry. Individuals who provide direct care and have consistent access to elders in long-term care environments are mostly such licensed personnel. When unlicensed personnel have access to elders in long-term care situations, they are supervised by those who are licensed. All licensed health care facilities, along with both licensed and unlicensed personnel, are mandated to report elder abuse, neglect or exploitation by statute to state and federal authorities. If abuse happens, there are individuals who will see it and have a duty to report it.

Prohibited Employees: Any person who is convicted of abusing, neglecting, or exploiting another is prohibited from being employed by a licensed health care facility. Additionally, in cases of abuse, neglect, or exploitation of a person who is a resident or patient of a licensed health care facility, a conviction is not necessary to bar the perpetrator from employment. In those instances, "substantial evidence" regarding the alleged crime is sufficient grounds to prohibit employment in a licensed health care facility. Through background checks, employment history, etc., the onus is on the licensed health care facility to ensure that their employees are not prohibited. During the Department's inspections of licensed health care facilities, inspectors review a sample of employees to ensure the facility is in compliance with the prohibited employee regulations. Such a check rarely finds offenders, as licensed facilities generally do their homework before hiring someone; failing to perform a diligent background examination may result in substantial liability if any prior offender hurts an elder in their care. *See Kirlin v. Halverson*, 2008 S.D. 107, ¶ 48, 758 N.W.2d 436, 452-53.

Wide-Scoped and Longstanding Records System: The Department of Health and Department of Social Services routinely share information on reports of suspected abuse, neglect, and exploitation of elders, partnering on a number of investigations. Further, the Department of Health's abuse rules have no time restrictions. Thus, abusive violations that occur over a decade ago will still result in individuals appearing on the red flag list.

Recommendation: The Departments of Health and Social Services ask that the Task Force consider these points in its determination of whether to advocate for a central registry of elder abuse, neglect, and exploitation. We recommend against the creation of such a central registry as a slight, additional layer of mostly redundant protection whose benefits will be outweighed by the burden on a finite state budget.

The Departments would instead suggest the Task Force recommend to the Legislature that the Department of Health's regulatory definition of elder abuse be expanded to include the expanding criminal definition advocated by the Task Force. The Departments would support that reform as an alternative to the central registry. As the status quo's infrastructure and regulatory oversight is already sufficient to protect elders in licensed health care institutions, we need to make sure that the Departments' efforts keep pace with, and compliment, the Task Force's work.

DSS's Estimate of Operating Costs of a Central Registry

Initial Placement on the Central Registry

When an individual is initially placed on the Central Registry, the process starts at the local office. Some local offices review each substantiated case in a Structured Team Response (STR) in which the supervisors of the Region come together and discuss the case to ensure adequate information to substantiate abuse/neglect. This process takes two hours - one hour of prep and one hour of discussion per supervisor.

Once the decision is made to place an individual on the Central Registry, the supervisor initiates the process and ensures all the correct documents are scanned in the electronic file system. This takes approximately 1 hour per week per supervisor.

The Regional Manager then reviews the file and sends out a certified letter to the individual notifying them of the placement on the Central Registry. The Regional Manager is responsible for tracking each of the individuals to monitor if they appeal or respond regarding placement on the Central Registry. This takes approximately 1 hour per week per Regional Manager. *598

In FY 15, Child Protection had a total of 598 substantiations

Total time: 4 hours per substantiated case, **cost of $114**

Appeal of Initial Placement on the Central Registry

Should the individual appeal the decision of the initial placement on the Central Registry, this process adds another 8-10 hours per case for the Regional Manager. This time includes the review, prepping of witnesses, and sending certified letters. This does not include the hearing time. These cases are often reviewed by Program Specialist and/or Deputy Director. Each review is approximately 1 hour in length.

Total time: 12 hours per appealed case for a **cost of $431**. This does not include Division of Legal Services expenses.

Initial Screening for the Central Registry

The Program Assistant is responsible for the initial screening of all Central Registry screening requests. She receives an average of 60 screenings each business day. These screenings are for purposes of adoption, foster care, kinship care, child care, employment at a child placement agency, employment at group/residential facilities, CASA volunteers, Child Protection Teams, employees of Child Protection Services, Head Start Programs, before/after school programs, caretakers through Department of Corrections, and tribal child welfare.

In order to complete the screening, she must look to see if the applicant and each of the applicant's children has history with CPS and if they do, the case has to be thoroughly reviewed. If the screenings are clear, meaning there are no substantiated findings, the Program Assistant stamps the screening form, initials it, and sends the form back to the requesting agency. This process is estimated at 5-15 minutes per screening. Depending on the number of children, the process can take up to 30-60 minutes for large families.

Total time: 15 minutes per screening, equating to **cost of $4**

If the Program Assistant finds substantiated history, a paper file is started to be sent to the Program Specialist. The Program Specialist reviews the entire file and determines if the substantiation should be upheld and if the individual received adequate due process. A certified letter is then sent to the requesting agency. When there is substantiated history, this process is estimated to take an additional 30-60 minutes for the Program Assistant and 30-60 minutes for the Program Specialist.

Total time if screening results in substantiated findings: 2 hours, **cost of $47.**

Waiver Requests

Individuals have the right to request a waiver to remove their name from the Central Registry after a period of 5 years. In order to do so, the individual submits a written

request. The Program Assistant researches the individual's file, as well as all of the individual's children and their files. Depending on the number of children and the amount of history, this process takes 60-90 minutes.

This file is then sent to the Program Specialist and reviewed in its entirety to make a determination if the individual is eligible for a waiver. The file is also reviewed to ensure adequate substantiations and due process. Certified letters are sent to the individual informing them of the steps required and paperwork needed to proceed with the waiver. This process takes 30-60 minutes. Consultation with the Deputy Director may also be necessary.

Total time: 3 hours, **cost of $72**.

If the individual follows through with the request and submits the documentation required, the Program Specialist reviews the documentation to make a determination. At times, additional documentation is required and the applicant is contacted again. This process takes 30-90 minutes, for a **cost of $46.**

If a waiver is denied and the individual requests a fair hearing to dispute the denial**,** an additional 2.5 hours is added, for a **cost of $77**, not including the hearing time or consultation with the Division of Legal Services.

Total for 598 Substantiations in FY15		**$68,172.00**
Initial Placement on the Central Registry	4 hours	$114.00
(Supervisor 3 hours, Regional Manager 1 hour, 1 certified letter)		
Total for 22 Appeals in FY15		**$9,482.00**
Appeal of Initial Placement on the Central Registry	12 hours	$431.00
(Regional Manager 10 hours, Program Specialist 1 hour, Deputy Director 1 hour, 3 certified letters)		
Total for 15,000 Screenings in FY15		**$60,000.00**
Initial Screening for the Central Registry	15 minutes	$4.00
(Program Assistant 15 minutes)		
Total for Substantiated Findings and Waiver Requests		**Variable**
Initial Screening if Substantiated Findings	2 hours	$47.00
(Program Assistant 1 hour, Program Specialist 1 hour, 1 certified letter)		
Waiver Requests – initial request	3 hours	$72.00

(Program Assistant 1.5 hours, Program Specialist 1 hour, Deputy Director ½ hour, 1 certified letter)

Waiver Request – follow through	1.5 hours	$46.00

(Program Specialist 1.5 hours, 1 certified letter)

Waiver Request – appeal	2.5 hours	$77.00

(Program Specialist 2 hours, Deputy Director ½ hour, 1 certified letter)

Estimated Total for FY15	**$137,654.00+**

Amounts are calculated by using salary rates of positions responsible for carrying out the specific task and does not include consultation of Legal Services which are included on the next page.

Appeal of Initial Placement on the Central Registry – Legal

Expenses When an individual appeals the decision of placement on the Central

Registry, this
process includes review of the case by the senior litigation supervisor and preparation and participation in the appeal hearing by the litigation supervisor or trial attorney. This time includes the review, coordinating and preparing witnesses, traveling to the hearing typically held 200-300 miles from Pierre, and participating in the hearing. Preparation and review typically takes 7 hours. Travel to and participation in the appeal hearing typically takes 8 hours. Additionally, the administrative law judge must travel to and conduct the hearing and prepare a decision. This typically takes 12 hours.

Total time: 27 hours per appealed case, mailing and administrative fees, and travel expenses for a **cost of $1095**.

(Senior Litigation Supervisor 1 hour, Litigation Supervisor 14 hours, Administrative Law Judge 12 hours, mailing and administrative fees, travel costs)

In FY 15, Legal Services had a total of 22 appeals

Total for 22 Hearings in FY15	**$24,090.00**

Appeal of Initial Placement on the Central Registry	27 hours	$1095.00

Grand Total for FY15	**$161,744.00+**

B. Minority Report: The potential for abuse wherein persons found committing abuse move from position to position outside of employment in licensed and certified service programs warrants a substantiated abuse and offendercentral registry available to the public to ensure that abusers are not invited into positions to offend again.

Recommendation 6: Increase the penalty for theft by exploitation of an elder or adult with a disability.

Section 21. That § 22-46-3 be amended to read as follows:

22-46-3. Any person who, having assumed the duty voluntarily, by written contract, by receipt of payment for care, or by order of a court to provide for the support of an elder or a disabled adult, and having been entrusted with the property of that elder or disabled adult, with intent to defraud, appropriates such property to a use or purpose not in the due and lawful execution of that person's trust, is guilty of theft by exploitation. Theft by exploitation is a Class 6 felony if the appropriated property is less than or equal to one thousand dollars in value. If the appropriated property exceeds one thousand dollars in value, theft by exploitation is punishable as theft pursuant to chapter 22-30A.

Commentary—Criminal exploitation (theft by exploitation) differs from the general definition of exploitation in SDCL 22-46-1, as the former requires that the perpetrator have a caretaker-like duty and be entrusted with the property at the time of the wrongful appropriation. Like the proposed language defining caretakers as voluntary for purposes of criminal neglect or emotional and psychological abuse in Section 1, the Task Force proposes this change so that the duty can be voluntary.

The Task Force proposals would likely increase penalties for most occurrences of theft by exploitation based on conviction statistics for theft in South Dakota—despite the near lack of charging SDCL 22-46-3 offenses, and only seven convictions over the last five years. The Task Force determined general theft was the closest offense to theft by exploitation that resulted in regular convictions. Those conviction statistics indicated that over 90% of theft convictions were non-felony convictions. Therefore, the Task Force determined that most thefts by exploitation, if reported and charged, would similarly be misdemeanors. Indeed, according to court records on the limited number of convictions for violations of SDCL 22-46-3, 80% of those convictions since 1990 have been misdemeanors.

Additionally, the Task Force did not want to dilute existing punishments for theft by exploitation amounting to grand or aggravated grand theft. Such

penalties are based on amount, and can go as high as a Class 2 felony for aggravated grand theft (over $500,000). See SDCL 22-46-3, 22-30A-17.1. *The more serious types of theft by exploitation should be subject to the same type of more serious punishments authorized for theft violations in general.*

Recommendation 7: Clarify the standards for reporting the abuse, neglect, or exploitation of an elder or adult with a disability.

A. Mandatory Reporter Statute

Section 22. That § 22-46-9 be amended to read as follows:

22-46-9. Any ~~person who is a~~:

(1) Physician, dentist, doctor of osteopathy, chiropractor, optometrist, podiatrist, religious healing practitioner, hospital intern or resident, nurse, paramedic, emergency medical technician, social worker, or any health care professional;

(2) Long-term care ombudsman;

(3) Psychologist, licensed mental health professional, or counselor engaged in professional counseling; or

(4) State, county, or municipal criminal justice employee or law enforcement officer;

who knows, or has reasonable cause to suspect, that an elder or ~~disabled~~ adult with a disability has been or is being abused ~~or~~, neglected, or exploited, shall, within twenty-four hours, report such knowledge or suspicion orally or in writing to the state's attorney of the county in which the elder or ~~disabled~~ adult with a disability resides or is present, to the Department of Social Services, or to a law enforcement officer. Any person who knowingly fails to make the required report is guilty of a Class 1 misdemeanor.

A person described in this section is not required to report the abuse, neglect, or exploitation of an elder or adult with a disability if the person knows that another person has already reported to a proper agency the same abuse, neglect, or exploitation that would have been the basis of the person's own report.

Commentary—The language above is modified to include person-first language, aswell as to clarify—assome had interpreted—that exploitationis a form of abuse that must also be reported by mandatory reporters.

Admittedly, the individuals listed above are not necessarily financial experts, but "reasonable cause" is a high threshold. Reasonable cause does not hinge on technical knowledge, but instead bears on whether a reasonable and prudent person, operating in everyday life, should act given the circumstances. See State v. Smith, 2014 S.D. 50, ¶ 19, 851 N.W.2d 718, 725 (quoting State v. Hirning, 1999 S.D. 53, ¶ 13, 592 N.W.2d 600, 604). Such abuse, neglect, or exploitation—evident to the average person without any technical knowledge—can and should be reported.

At the August 18 Task Force meeting, the Elder Financial Exploitation Committee relayed its support for mandatory reporting of financial exploitation to include financial institutions. However, the Board of Directors of the South Dakota Bankers Association unanimously rejected mandatory reporting as well as the Class 1 misdemeanor for financial institutions' employees' failure to report. It suggested instead that the Task Force adopt a permissive reporting process for financial institutions that also outlines when and how law enforcement can obtain additional nonpublic personal information from financial institutions in any follow-up investigation. Without these measures, financial institutions are concerned their reporting and cooperation will violate federal privacy regulations. Ultimately, the Task Force did not recommend that financial institutions be included as mandatory reporters

The new sentence at the end of the proposal above comes from Colorado statute. It is designed to accommodate large institutions that have an internal, specialized process for reporting that may not rely entirely on the mandatory reporter who witnessed the suspicious activity

Section 23. That chapter 22-46 be amended by adding thereto a NEW SECTION to read as follows:

The person making a report as required by § 22-46-9 and as permitted by § 22-46-11 shall provide, or a proper agency receiving the report shall acquire, to the extent possible, the following information:

(1) The name, age, physical address, and contact information of the elder or adult with a disability;

(2) The name, age, physical address, and contact information of the person making the report;

(3) The name, age, physical address, and contact information of the caretaker of the elder or adult with a disability;

(4) The name of the alleged perpetrator;

(5) The nature and extent of the elder or adult with a disability's injury, whether physical or financial, if any;

(6) The nature and extent of the condition that required the report to be made; and

(7) Any other pertinent information.

Commentary—South Dakota's vulnerable adult abuse reporter law, unlike most other states' provisions, does not specify the information that should be included in a report. The Task Force recommends such information be specified. This proposal is taken from Colo. Rev. Stat § 18-6.5-108(2)(a).

B. Statute Clarifying Law Enforcement Responsibility

Section 24. That § 22-46-5 be amended to read as follows:

22-46-5. The person or agency that receives, pursuant to § 22-46-7, a report of abuse, neglect, or exploitation of an elder or adult with a disability shall also forward the report to the Office of the Attorney General, if the person or agency determines that reasonable suspicion exists to support further investigation. In investigating violations of this chapter, law enforcement agencies shall cooperate with and assist the Department of Social Services. A law enforcement agency shall complete a criminal investigation when appropriate.

Commentary—The Task Force initially felt that there needed to be some record of an elder financial exploitation report being made given the limitations of the federal online portal for submitting suspicious financial activity reports (FinCEN). The Task Force then expanded this concern to include elder abuse and neglect reporting as well. The Task Force believes

that the Attorney General's Office, and particularly the specialists advocated for in Recommendation 8, would be an appropriate repository.

Office of the Attorney General Commentary—The South Dakota Office of Attorney General (SDAG) supports Recommendation 8, which would provide two additional FTE and additional resources to SDAG. SDAG would need the two FTE and additional resources if it is the intent to have the SDAG increase or broaden its involvement in the investigation and prosecution of cases involving alleged abuse, neglect, and financial exploitation.

SDAG also supports the proposed amendment of SDCL 22-46-5, assuming that Recommendation 8 is fully implemented. However, if Recommendation 8 is not fully implemented, SDAG does not have sufficient FTE or resources to fully implement the Task Force's intent behind the proposed amendment of SDCL 22-46-5.

C. Statute Expanding Voluntary Reporting to Exploitation for the General Public

Section 25. That § 22-46-11 be amended to read as follows:

22-46-11. Any person who knows or has reason to suspect that an ~~elderly or disabled~~ elder or adult with a disability has been abused ~~or~~, neglected, or exploited as defined in ~~§ 22-46-2 or 22-46-3~~ §§ 22-46-1 to 22-46-3, inclusive, may report that information, regardless of whether that person is one of the mandatory reporters listed in §§ 22-46-9 and 22-46-10.

Commentary—The Task Force recommends that the voluntary reporting statute more clearly authorize voluntary reporting of all abuse, neglect, and financial exploitation of an elder or adult with a disability. This revision is also intended to lessen the concern of some financial institutions that voluntary reporting may violate federal privacy laws.

D. Adopt a Permissive Reporting System for Financial Institutions and a Form to Request Financial Information from Financial Institutions

Section 26. That chapter 37-24 be amended by adding thereto a NEW SECTION to read as follows:

A financial institution, as defined in 31 U.S.C. § 5312(a)(2), who voluntarily or mandatorily reports via a suspicious activity report, pursuant to 31 U.S.C. § 5318(g), any possible violation of law or regulation constituting exploitation, as defined in subdivision 22-46-1(5), may also report the information contained in the suspicious activity report to state or local law enforcement. A financial institution is immune from any civil or criminal liability that might otherwise result from complying with this section.

Section 27. That chapter 37-24 be amended by adding thereto a NEW SECTION to read as follows:

A financial institution shall cooperate with any lead investigative agency, law enforcement, or prosecuting authority that is investigating the abuse, neglect, or exploitation of an elder or adult with a disability and comply with reasonable requests for the production of financial records. A financial institution is immune from any civil or criminal liability that might otherwise result from complying with this section.

Commentary—After eschewing mandatory reporting, financial institutions asked the Task Force to provide them with maximum reporting flexibility, coupled with immunity for reporting. This suggested language provides immunity at the initial reporting stage (by the first proposed section) and at the subsequent investigatory and prosecutorial stages (by the second proposed section).

Recommendation 8: Employ a new prosecutor and a new investigator in the Office of the Attorney General to specialize in prosecuting and investigating abuse, neglect, and exploitation of elders and adults with a disability.

Commentary—The Task Force received consistent public testimony on the lack of prosecution of financial exploitation and the difficulties of prosecuting the crime. The Task Force recommends that the Legislature appropriate funds for an attorney-specialist, within the Office of the Attorney General, whose role would be to prosecute or to assist state's attorneys in prosecuting the abuse, neglect, and financial exploitation of elders or adults with disabilities. The attorney-specialist would also serve as an educational resource and liaison for local and tribal law enforcement. The Task Force also recommends that the Legislature appropriate funds for an investigator specializing in these cases to assist the attorney in bringing criminal charges and providing education on this topic.

Recommendation 9: Create a civil right of action for elders and adults with a disability to recover damages from exploitation.

Section 28. That chapter 22-46 be amended by adding thereto a NEW SECTION to read as follows:

A court may find that an elder or adult with a disability has been exploited as defined in § 22-46-1 or § 22-46-3. If a court finds exploitation occurred, the elder or adult with a disability has a cause of action against any perpetrator and may recover actual and punitive damages for the exploitation. The action may be brought by the elder or adult with a disability, or that person's guardian, conservator, by a person or organization acting on behalf of the elder or adult with a disability with the consent of that person or that person's guardian or conservator, or by the personal representative of the estate of a deceased elder or adult with a disability without regard to whether the cause of death resulted from the exploitation. The action may be brought in any court of competent jurisdiction to enforce the action. A party who prevails in the action may recover reasonable attorney's fees, costs of the action, compensatory damages, and punitive damages.

> *Commentary—This section is taken from Florida statute. To provide the protection needed, the Task Force proposes language that provides (1) attorney's fees and court costs, (2) punitive (or additional) damages, and (3) a mechanism by which other interested parties may bring suit on behalf of the elder or adult with a disability. The remaining sections, found below, are taken from Arizona statute.*

Section 29. That chapter 22-46 be amended by adding thereto a NEW SECTION to read as follows:

In addition to the damages prescribed in section 28 of this Act, the court may impose the following penalties:

(1) Order the perpetrator to forfeit all or a portion of the person's:

(a) Interest in any governing instrument executed by the elder or adult with a disability; and

(b) Benefits under chapter 29A-2, with respect to the estate of the elder or adult with a disability, including an intestate share, an elective share, an omitted spouse's share, an omitted child's share, a homestead allowance, any exempt property and a family allowance. If the elder or adult with a disability died intestate, the elder or adult with a disability's intestate estate passes as if the perpetrator disclaimed that person's intestate share to the extent the court orders that person to forfeit all or a portion of the person's benefits under chapter 29A-2;

(2) Revoke, in whole or in part, any revocable:

(a) Disposition or appointment of property that is made in a governing instrument by the elder or adult with a disability to the perpetrator;

(b) Provision by the elder or adult with a disability that is contained in a governing instrument that confers a general or nongeneral power of appointment on the perpetrator; and

(c) Nomination or appointment by the elder or adult with a disability that is contained in a governing instrument that nominates or appoints the perpetrator to serve in any fiduciary or representative capacity, including serving as a personal representative, executor, guardian, conservator, trustee, attorney in fact, or agent;

(3) Sever the interests of the elder or adult with a disability and the perpetrator in any property that is held by them at the time of the violation as joint tenants with the right

of survivorship and transform the interests of the elder or adult with a disability and the perpetrator into tenancies in common. To the extent that the perpetrator did not provide adequate consideration for the jointly held interest, the court may cause the person's interest in the subject property to be forfeited in whole or in part.

Section 30. That chapter 22-46 be amended by adding thereto a NEW SECTION to read as follows:

A severance pursuant to subdivision (3) of section 29 of this Act does not affect any third party interest in property that was acquired for value and in good faith reliance on apparent title by survivorship in the perpetrator unless a writing declaring the severance has been noted, registered, filed, or recorded in records that are appropriate to the kind and location of the property and that are relied on as evidence of ownership in the ordinary course of transactions involving that property.

Section 31. That chapter 22-46 be amended by adding thereto a NEW SECTION to read as follows:

If the court imposes a revocation pursuant to subdivision (2) of section 29 of this Act, provisions of the governing instrument shall be given effect as if the perpetrator disclaimed all provisions revoked by the court or, in the case of a revocation of a nomination in a fiduciary or representative capacity, the perpetrator predeceased the decedent.

Commentary—Sections 29 through 31 provide a "Slayerstatute"-equivalent for exploiters, sharing the same provisions as South Dakota'sexisting "Slayer" statute that divests a murderer of any inheritance or benefit from the person he or she killed. See SDCL 29A-2-803. These remedies are somewhat similar to the civil right of action proposed for elder abusers and neglecters (Sections 14 and 15, on pages 25-26), but instead of simply divesting the offender of control of the elder or disabled adult's finances, these provisions also empower a court to divest the offender benefits, including probate and non-probate interests and other joint accounts. Note also that convictions under the theft bydeception statute, SDCL 22-46-3, will, bythisproposal, authorize

a court sitting in civil jurisdiction to utilize these remedies against the defendant.

Section 32. That chapter 22-46 be amended by adding thereto a NEW SECTION to read as follows:

The court may utilize the remedies provided in section 14 of this Act for violations under section 28 of this Act or § 22-46-3.

Commentary— This section, taken from Arizona, cross-references the remedies available in the elder abuse and neglect civil right of action. The civil right of action is found in Sections 3 through 20. By cross-referencing the civil right of action remedies, a court would be permitted to also order an exploiter to not exercise control, to return custody or control, to follow a fiduciary's instructions, and to prohibit transfers regarding an elder's assets.

Section 33. That chapter 22-46 be amended by adding thereto a NEW SECTION to read as follows:

The remedies provided in section 28 through section 32, inclusive, of this Act are in addition to and cumulative with other legal and administrative remedies available to an elder or adult with a disability.

Recommendation 10: Create a form for establishing a durable power of attorney for financial decisions and enact legislation to better protect principals under durable powers of attorney.

A. State Bar Drafting Form Language for Durable Financial Powers of Attorney

Commentary—The Task Force recommends that the State Bar of South Dakota create a committee of practitioners and other legal experts that specialize in powers of attorney. Noting the State Bar's successful efforts to create a durable health care power of attorney and its placement of the form on its website for public access, the Task Force recommends a similar form be prepared and adopted by the State Bar for financial powers of attorney, and that it be made available on the State Bar's website. The Task Force requests that this form be completed by the State Bar and uploaded to its website no later than January 1, 2017.

B. Amending Existing Durable Power of Attorney Statutes to Provide Formal Protections for Vulnerable Adults

Section 34. That § 59-7-2.1 be amended to read as follows:

59-7-2.1. Notwithstanding § 59-7-2, if a principal designates another as the principal's attorney in fact or agent by a written power of attorney which contains the words "This power of attorney shall not be affected by disability of the principal," or "This power of attorney shall become effective upon the disability of the principal," or similar words showing the intent of the principal that the authority conferred is exercisable notwithstanding the principal's disability, the authority of the attorney in fact or agent is exercisable by the attorney in fact or agent as provided in the power on behalf of the principal notwithstanding any later disability or incapacity of the principal or later uncertainty as to whether or not the principal is dead or alive.

<u>The durable power of attorney must be signed by the principal or in the principal's conscious presence by another individual directed by the principal to sign the principal's name on the power of attorney. The signature must be witnessed by two other adult individuals.</u> A power

of attorney granted pursuant to this section may authorize the attorney-in-fact to consent to, to reject, or to withdraw consent for health care, including any care, service, or procedure to maintain, diagnose, or treat a person's physical or mental condition.

> *Commentary—By statutory definition, a durable power of attorney is effective when the principal (the person who created the durable power of attorney to allow another to make decisions on the principal's behalf regarding the principal's person or property) lacks soundness of mind or decisional capacity. In other words, individuals rely on these documents when they are at their most vulnerable, regarding their most cherished concerns. The Task Force, at an early stage, became aware of the lack of formalitiesrequiredfor adurablepower of attorney, making theseimportant legal documents susceptible to abuse. The proposed statutory language is meant to prohibit the most egregious potential for abuse by requiring the principal's signature be affixed to the power of attorney and witnessed by two other adults.*
>
> *The Task Force also recommends that the State Bar's Real Property Committee look at whether the Uniform Power of Attorney Act should be adopted in South Dakota.*

Recommendation 11: Identify educational resources and suggest a public awareness campaign for elder abuse.

Elder Abuse Task Force Education Committee Report to the Legislature

The members of the Elder Abuse Task Force (EATF) Education Committee, Sarah Jennings (AARP SD/Committee Chair), Jennifer Murray (SD Department of Social Services), Kristina Schaefer (Fishback Financial Corporation), Jody Swanson (SD Attorney General Office), and Senator David Novstrup (State Senator), have agreed to continue their work into 2016 to complete the larger outreach efforts for the Elder Abuse Task Force. Though communication has begun, many key messages cannot be shared with the target audiences until the Legislature has taken action during the 2016 session on Task Force recommendations.

Timeline: The timeline to implement the full EATF outreach and communications plan will begin on January 13, 2016 with an awareness campaign regarding the work of the Elder Abuse Task Force. It will continue throughout the session with legislative and partner outreach surrounding specific Task Force supported proposals. Outreach to general audiences will begin with messaging that has been developed based on priority message for the specific audience (see chart below) and action taken during session. The peak of the outreach and awareness campaign will be focused around Elder Abuse Awareness Month in June 2016. Education Committee members also offer to do a report in mid or late 2016 to the Chief Justice and/or legislative representatives if desired.

Committee Goals:

- Ensure Task Force goals are met through our educational initiatives including generating legislative support, getting media outreach highlighting Task Force work, increasing awareness, and improvingtraining.
- By the end of 2016, the education and outreach effort will recruit at least 10 Stakeholders/Champions to help with outreach and reach 5,000 seniors, 200 family caregivers, financial service professionals across the state, and 30,000 mandatory reporters through education and communication efforts.

2016 Outreach Overview:

Target Audience	Primary Messaging	Does Collateral exist to deliver?
Health Professionals	• Mandatory reporting requirements, responsibilities andprotections • Signs of abuse	Yes. DSS brochure ($.10 each). Committee looking into e-version, short video to accompany.
Law Enforcement	• General awareness on the issue and signs ofabuse • Understanding the means by which elder abuse is facilitated, both in criminal and civil contexts. • Suggestions for investigating elder abuse, knowing the various charging options, and understanding who may be a partner in investigating and preventing elder abuse.	Yes. ABA pocket guide & Desk Guide. Committee considering if anything else needed to accompany the existing collateral.

Financial Institutions - Staff	• General awareness on the issue and signs of abuse • What to do if suspect abuse? Protections of whistleblowers	In Development. American Bankers Association is developing new materials to be launched in early 2016.
Financial Institutions - Consumers	• How to protect your assets and avoid fraud or exploitation • Power of Attorney Guidance (Highlighting the Power to Make Gift issue)	In Development. American Bankers Association is developing new materials to be launched in early 2016.
Tribal	• General Awareness/signs of abuse • What to do if suspect abuse? (Guidance will be different than that to General Public)	In Development. Trying to identify a Lead Agency. AARP staff is reaching out to other organizations to find existing resources.
Family Caregivers	• General awareness and signs of abuse • What to do if you suspect abuse • What to look for in a home health aid • Power of Attorney Guidance (Highlighting the Power to Make Gift issue)	No. AARP taking lead on development.
Individuals/Victims	• Understanding your rights and how to protect yourself from abuse • What to do if you feel you are being abused or financially exploited • Power of Attorney Guidance (Highlighting the Power to Make Gift issue)	Yes. SD Attorney General Consumer Protection Manual. Committee discussing companion piece to highlight certain issues. DSS has info also.
General Public	• Elder abuse does happen in SD – share information, signs of abuse and resources. • Share the work of the Task Force to protect our seniors from abuse starting on January 13 and continuing through session as legislative initiatives are considered.	Yes. All info exists but likely need to package it in a more consumer friendly format.

Recommendation 12: Amend statutes to provide that the appointment of a guardian or conservator divests an agent under a power of attorney of his or her conflicting authority and prevent powers of attorney from being used to circumvent guardianships or conservatorships.

Section 35. That chapter 59-7 be amended by adding thereto a NEW SECTION to read as follows:

If a conservator of the principal is appointed after the occurrence of the disability or incapacity referred to in § 59-7-2.1, any power of attorney authorizing an agent to act on the principal's finances or estate is terminated at the time of the appointment and the person acting under the power of attorney shall account to the conservator rather than to the principal.

Section 36. That chapter 59-7 be amended by adding thereto a NEW SECTION to read as follows:

If, after a principal executes a power of attorney for health care pursuant to § 59-7-2.1, a court appoints a guardian of the principal's person, the power of attorney is terminated at the time of the appointment, but the guardian shall follow any provisions contained in the power of attorney for health care delineating the principal's wishes for medical and end-of-life care.

Commentary—The Task Force sought a bright-line determination that powers of attorney cease to be effective where they conflict with a court appointment of a guardian or conservator. Section 35 is taken from a Connecticut statute providing that when a conservator is appointed, the agent/attorney-in-fact under a conflicting financial power of attorney ceases to have authority under the POA and must account to the conservator. Section 36, taken from Nevada, is an equivalent provision for guardians and health care powers of attorney. However, unlike financial instructions, the instructions in a health care power of attorney are less technical and are related to the most fundamental decisions a person can make, hence its more deferential treatment by the guardian.

The Task Force believes that a guardianship or conservatorship should trump a power of attorney when they conflict because a guardian or conservator must report their actions to a court, while an agent under a power of attorney has a duty only to report to the principal, who by the time of a guardian or conservator appointment is often unable to hold an agent to account. Accordingly, the guardian or conservator is more answerable for their actions.

Section 37. That § 29A-5-118 be amended to read as follows:

29A-5-118. The appointment of a guardian or conservator of a protected person does not constitute a general finding of legal incompetence unless the court so orders, and the protected person shall otherwise retain all rights which have not been granted to the guardian or conservator, with the exception of the ability to create an agency and confer authority on another person to do any act that the protected person might do, pursuant to § 59-2-1. Unless prior authorization of the court is first obtained, a guardian or conservator may not change the residence of the minor or protected person to another state, terminate or consent to a termination of the minor's or protected person's parental rights, initiate a change in the minor's or protected person's marital status, or revoke or amend a durable power of attorney of which the protected person is the principal, except as provided in sections 35 and 36 of this Act.

Commentary—Under current statute, a protected party retains the ability to enter into future powers of attorney, even after appointment of a guardian or conservator, unless a court specifically finds the protected person legally incompetent. The changes above are in keeping with the suggested revision to SDCL 59-7-2.1, which are intended to establish that the appointment of guardians or conservators automatically terminates conflicting powers of attorney and prevents a power of attorney from being set up later to attempt to circumvent the guardian or conservator.

Recommendation 13: Prepare educational resources and establish a statutory training requirement for all guardians and conservators.

A. Guardianship Handbooks:

Commentary—The Task Force received anecdotal information that many problems arising out of guardianships or conservatorships are not the result of malice. Instead, most are from a lack of knowledge regarding a guardian or conservator's duties. Forty states have an official or semi-official handbook or pamphlet on guardian and/or conservator duties and best practices. South Dakota is not one of them. The Task Force recommends the State Bar of South Dakota develop a handbook to educate guardians and conservators on their duties and provide best practices.

B. Training Statutory Requirements:

Section 38. That chapter 29A-5 be amended by adding thereto a NEW SECTION to read as follows:

The State Bar of South Dakota shall prepare and approve training curricula for persons appointed as guardians and conservators. The training curricula shall include:

(1) The rights of minors and protected persons under chapter 29A-5 and under the laws of the United States generally;

(2) The duties and responsibilities of guardians and conservators;

(3) Reporting requirements;

(4) Least restrictive options in the areas of housing, medical care, and psychiatric care; and

(5) Resources to assist guardians and conservators in fulfilling their duties.

Each person appointed by the court to be a guardian or conservator must complete the training curricula within four months after the appointment as a guardian or conservator.

Commentary—The Task Force recommends that the State Bar prepare curricula that balance cost and accessibility with comprehensiveness and

rigor. The statutory training language above ensures the training is "required," but it should not be immediately effective, in order to give the Bar time to work.

Special Writing—A member of the Task Force requested that whatever training requirement is established, the cost of the training should be disclosed plainly and up front.

Recommendation 14: Encourage the court system to further monitor guardians and conservators using existing court electronic resources.

- Create an automated letter that goes out to all active guardians and conservators (as well as their principals, either protected persons or minors), that have not had their annual accounting requirement waived. Each year, that letter will issue two months prior to April 15, the deadline set for annual reporting and accounting. *See* SDCL 29A-5-403 (reports), 29A-5-408 (accountings).

- Create a search report for clerk's offices that runs on April 16 (or the first business day thereafter) to notify the court as to which guardians and conservators failed to file their annual report or accounting.

- Redouble efforts to ensure courts use the right events in its case management system to permit this process to automate effectively, specifically for these events:

    - Terminating a guardianship or conservatorship.
    - Waiving (or otherwise modifying) the accounting requirement.
    - Accepting a guardian's report or a conservator's accounting.

Commentary—The UJS's Odyssey Electronic Records System appears to be configurable to assist the courts in alerting guardians and conservators to their reporting requirements and monitor to see that the reports and accountings were actually filed. The Task Force was informed that the UJS does have the ability to make these modifications.

Recommendation 15: Require background checks for all proposed guardians and conservators, and prohibit felons from serving as guardians or conservators unless a court finds special circumstances.

Section 39. That § 29A-5-110 be amended to read as follows:

29A-5-110. Any adult individual may be appointed as a guardian, a conservator, or both, if capable of providing an active and suitable program of guardianship or conservatorship for the minor or protected person, and if not employed by any public or private agency, entity, or facility that is providing substantial services or financial assistance to the minor or protected person.

> *Commentary—The Task Force could think of no reason why only public agencies were excluded from acting as guardians while simultaneously providing substantial services or financial assistance. Private agencies provide similar services, and their employees would have a similar conflict of interest if they were to be appointed as a fiduciary—perhaps an even greater conflict considering their profit motive.*

Any public agency or nonprofit corporation may be appointed as a guardian, a conservator, or both, if it is capable of providing an active and suitable program of guardianship or conservatorship for the minor or protected person, and if it is not providing substantial services or financial assistance to the minor or protected person.

Any bank or trust company authorized to exercise trust powers or to engage in trust business in this state may be appointed as a conservator if it is capable of providing a suitable program of conservatorship for the minor or protected person.

The Department of Human Services or the Department of Social Services may be appointed as a guardian, a conservator, or both, for individuals under its care or to whom it is providing services or financial assistance, but such appointment may only be made if there is no

individual, nonprofit corporation, bank or trust company, or other public agency that is qualified and willing to serve.

No individual or entity, other than a bank or trust company, whose only interest is that of a creditor, is eligible for appointment as either a guardian or conservator.

No individual who has been convicted of a felony is eligible for appointment as a guardian or conservator unless the court finds appointment of the person convicted of a felony to be in the best interests of the person for whom the guardianship or conservatorship is sought. As part of the best interest determination, the court shall consider the nature of the offense, the date of offense, and the evidence of the proposed guardian's or proposed conservator's rehabilitation. No person may be appointed who has been convicted of a felony involving harm or threat to a minor or an elder or an adult with a disability, including a felony sexual offense.

> *Commentary—The Task Force recommends that convicted felons should generally be excluded from serving in fiduciary capacities, but a circuit judge should be given discretion to find it is in a principal's best interest to have a felon (such as a family member with a very attenuated felony conviction) serve in that capacity. It is often difficult for a court to find someone who is willing or able to serve in such important roles.*

A person, except for a financial institution or its officers, directors, employees, or agents, or a trust company, who has been nominated for appointment as a guardian or conservator, shall obtain an Interstate Identification Index criminal history record check and a record check of South Dakota state court civil judgments for abuse, neglect, or exploitation of an elder or adult with a disability. The nominee shall file the results of these record checks with the court at least ten days prior to the appointment hearing date, unless waived or modified by the court for good cause shown by affidavit filed simultaneously with the petition for appointment.

Commentary—The Task Force determined that the III Background Check was the most comprehensive yet cost-effective criminal background check available. Further, the Task Force is aware that certain civil judgments may not rise to the level of culpability of criminal convictions but nevertheless indicate a history of abusing vulnerable adults, and thus would be very relevant to acourt's appointment decision.

The judge may not sign an order appointing a guardian or conservator until the record check results have been filed with the court and reviewed by the judge. The record check results, or the lack thereof, shall be certified by affidavit. The court may not require a record check upon the application of a petitioner for a temporary guardianship or temporary conservatorship. The court may waive the requirements of this section for good cause shown.

Commentary—The Task Force wanted to ensure that an exception to a time-intensive background check existed for "emergency" guardianship or conservatorship situations. The Task Force also wanted to ensure that a "good cause" safety valve existed for other exceptional situations in which the need for guardianships and conservatorships manifests.

Recommendation 16: Require sureties to notify the court and the protected person, minor, or estate if a guardian or conservator bond is not renewed.

Section 40. That § 29A-5-111 be amended to read as follows:

29A-5-111. The appointment of a guardian or conservator does not become effective nor may letters of guardianship or conservatorship issue until the guardian or conservator has filed an acceptance of office and any required bond.

The court may not require the filing of a bond by a guardian except for good cause shown.

The court shall determine whether the filing of a bond by a conservator is necessary. In determining the necessity for or amount of a conservator's bond, the court shall consider:

(1) The value of the personal estate and annual gross income and other receipts within the conservator's control;

(2) The extent to which the estate has been deposited under an arrangement requiring an order of court for its removal;

(3) Whether an order has been entered waiving the requirement that accountings be filed and presented or permitting accountings to be filed less frequently than annually;

(4) The extent to which the income and receipts are payable directly to a facility responsible for or which has assumed responsibility for the care or custody of the minor or protected person;

(5) Whether a guardian has been appointed, and if so, whether the guardian has presented reports as required;

(6) Whether the conservator was appointed pursuant to a nomination which requested that bond be waived; and

(7) Any other factors which the court deems appropriate.

Any required bond shall be with such surety and in such amount and form as the court may order. The court may order additional bond or reduce bond whenever it considers such modification to be in the best interests of the minor, the protected person, or the estate.

The surety or sureties of the bond must immediately serve notice to the court and to the minor, the protected person, or the estate if the bond is not renewed by the guardian or conservator.

Commentary— Current law does not require mandatory bonding for guardians and conservators. The Task Force initially supported a regime in which bonding was mandated in all cases, but the court retained discretion to waive the bonding requirement. The Task Force's initial position proceeded from the idea that bonding companies will perform additional due diligence to ensure they do not take on a high risk obligee, thus subjecting themselves to potential liability. In that way, the bonding company acts like a gatekeeper, excluding high-risk potential guardians and conservators.

The Task Force discovered, however, that the most salient reason why statute currently disfavors bonding is that substantial bonding costs are passed on to the same protected person, minor, or estate the requirement is meant to protect, for little services ultimately provided by the surety. The Task Force found this burden too great relative to the minor additional protections afforded by a mandatory bonding requirement—protections made less necessary by the background check requirement proposed in Recommendation 15 on page 59.

In taking public testimony, the Task Force was made aware of instances where bonds were required by courts for conservatorships, and the conservators violated their fiduciary duties, only for the protected persons to find that the conservators' bonds had been expired for months, even years. Accordingly, the Task Force only recommends that sureties (who are ultimately paid by the protected persons, minors, and estates) serve the protected persons, minors, estates, and the court notice when the guardian- or conservator- fails to renew the bond during the guardianship or conservatorship.

Attachment K

History and Development

Creating and Designing the State Plan on Aging

In order to effectively create and design this State Plan on Aging, the Department sought comments and requested input and feedback from a multitude of sources including internal and external customers and key stakeholders such as government agencies, long term care providers, home and community-based services providers, legislators, consumers, Tribal offices, the Advisory Council on Aging, the South Dakota Health Care Association, the South Dakota Association of Healthcare Organizations, the Assisted Living Association of South Dakota, the American Association of Retired Persons, and the South Dakota Nutrition Association. The input and feedback described below was instrumental in formulating the State Plan on Aging.

Long Term Care Task Force

The Department convened an Long Term Care Task Force consisting of the Director and Deputy Director of the Division of Long Term Services and Supports, as well as, Program Specialists who are responsible for providing technical assistance to regional staff to ensure programs within Division of Long Term Services and Supports operate within set standards and that services are delivered effectively and efficiently across the state. Additionally, regional Long Term Services and Supports' Specialists across the state, who work closely with elderly South Dakotans and adults with disabilities providing intake, information and assistance, options planning, and case management services. Supervisors and Regional Managers who provide leadership and oversee the work of the Specialists also provided input and feedback regarding ways the State of South Dakota can fulfill the needs of older South Dakotans and adults with disabilities.

Advisory Council on Aging

Recommendations from various workgroups, the State Plan goals, objectives and strategies and the guidelines for use in developing and submitting the State Plan requirements were shared in detail with members of the Advisory Council on Aging. Recommendations received from Council members have been incorporated into the State Plan on Aging. The Advisory Council on Aging unanimously approved and expressed appreciation for the direction the State is taking in order to best meet the needs of South Dakota's elderly population. Information about the meetings is posted online as well as in locations where meetings are held prior to each meeting and the public is welcome to attend and provide comments and recommendations for future planning. Advisory Council on Aging members represents the Council as workgroup members of other key stakeholder initiatives.

AoA On-Site Review

South Dakota continues to participate in on-site reviews conducted by the regional office of the Administration on Aging, a unit within the Administration for Community Living, to discuss ongoing status of progress towards accomplishing goals and objectives in the State Plan on Aging. This review helps shape South Dakota's vision for the four year period of October 1, 2017 through September 30, 2021.

Outreach Events

The Division of Long Term Services and Supports continues to utilize outreach events as a novel approach to reaching rural individuals to discuss resident rights, elder protection, and services and programs available through the Aging and Disability Resource Connections, including core services of the Title III program. Additionally, representatives from the Senior Health Information and Insurance Education (SHIINE) program were available to discuss benefits related to Medicare services including information regarding Medicare fraud through the Senior Medicare Patrol (SMP). Outreach event locations are targeted at congregate nutrition sites in rural areas of South Dakota, including sites on Native American reservations. These outreach events continue to be well-received and instrumental in raising awareness and education to South Dakota citizens of all ages. Registration cards were provided at each event to get input from participants about their future needs.

Medicaid Solutions Workgroup

The Medicaid Solutions Workgroup, established by Governor Daugaard during the 2011 Legislative Session, solicited key stakeholder input to develop strategies to contain and control Medicaid costs while maintaining quality services for recipients. Since the release of the final report, the State of South Dakota has made significant progress towards completing the recommendations. One of the workgroups recommendations was to implement a “Health Home” initiative for Medicaid enrollees. The Health Home program was implemented in July 2013, and has demonstrated that person centered case management is an effective care management tool. Over 6,000 recipients have enrolled. Health Home providers have expressed that they are providing their person centered case management practices to other patients within their practice. Another recommendation of the Medicaid Solutions Workgroup was to evaluate the Money Follows the Person (MFP) option. MFP was implemented in July 2014, and has received 34 referrals of which nine individuals have transitioned from either a nursing facility or from the South Dakota Developmental Center in Redfield. Of those, nine individuals were eligible and transitioned into the community. Referrals continue to be received and evaluated by the MFP Coordinator. Additionally, the Medicaid Solutions Workgroup recommended the State implement a Durable Medical Equipment Recycling Program. A Request for Proposals was published in January 2015 to secure a vendor to warehouse, refurbish, clean and distribute the used durable medical equipment for Medicaid recipient use. In addition, a software package was identified to be utilized by the vendor for inventory tracking purposes, and program reporting.

HCBS Statewide Transition Plan

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) released a final rule regarding Home and Community-Based Services (HCBS) Setting requirements. The intent of the final rule is to ensure individuals in Medicaid's HCBS waiver programs receive services and supports in the most integrated setting and have full access to the benefits of community living. The Department of Social Services and the Department of Human Services worked collaboratively to review the final rule. Per the requirements of the final rule, South Dakota Medicaid developed a transition plan for HCBS settings in South Dakota to be approved by the Centers for Medicare and Medicaid Services (CMS). South Dakota’s original Home and Community Based Statewide Transition Plan was submitted to CMS on March 12, 2015. A Revised Statewide Transition Plan was submitted to CMS on April 6, 2016. The State of South Dakota continues to build a strong partnership with providers and is working closely with CMS and key stakeholders to ensure a smooth transition and continued compliance with the HCBS Settings Final Rule. The State of South Dakota continues to host webinars to educate assisted

living providers about expectations and compliance with the final rule to ensure individuals served by Medicaid receive services in the most integrated setting and have full access to the benefits of the community. The State of South Dakota's "*HCBS Statewide Transition Plan"* is located at https://dss.sd.gov/docs/medicaid/hcbs_revised_stp.pdf.

AARP Scorecard

In June 2014, the American Association of Retired People (AARP) released a state-by-state Long-Term Services and Supports Scorecard in follow-up to the initial scorecard AARP released in 2011. South Dakota's ranking was slightly higher than the previous scorecard. The AARP Scorecard showed that the percent of adults with disabilities in South Dakota communities are satisfied or very satisfied with life and as such, the State of South Dakota ranked very high in the areas of Quality of Life and Quality of Care. South Dakota's rate of employment for adults with disabilities was also rated very high. Additionally, 64.5% of family caregivers in South Dakota reported they were without much worry or stress, with enough time and well-rested, ranking South Dakota fourth in the U.S. South Dakota ranks second in the U.S. for private long-term care insurance policies in effect per 1,000 population age 40+. The report stated, "Our state has always prided itself in taking care of others and these scores prove that commitment yet again." According to the 2014 AARP Long-Term Services and Supports Scorecard, the State of South Dakota ranked low in the areas of Affordability and Access which in part is a challenge because of our geographically big state with a small population. The areas the Scorecard highlighted for improvement include:

- More low/moderate income adults with ADL disabilities would be covered by Medicaid;
- More new users of Medicaid Long-Term Services and Supports would first receive services in the community;
- More nursing home residents with low care needs would instead receive Long-Term Services and Supports in the community;
- More people entering nursing homes would be able to return to the community within 100 days; and
- More people who have been in a nursing home for 90 days or more would be able to move back to the community.

The AARP *"South Dakota: 2014 State Long-Term Services and Supports Scorecard Results"* Fact Sheet can be found in Attachment H

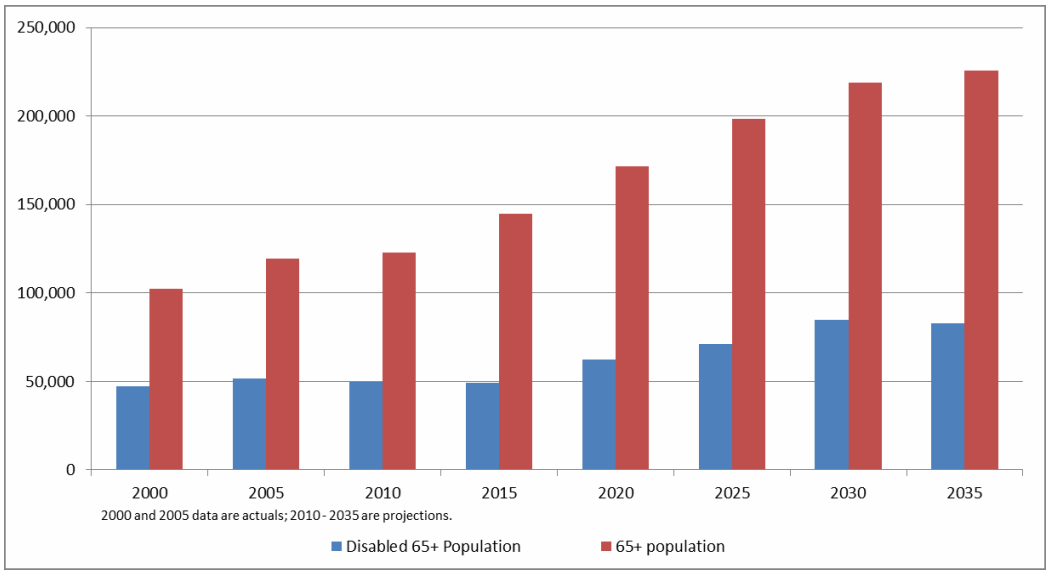
Updated Long Term Care Study 2015

In 2015, Abt Associates of Cambridge, Massachusetts was contracted by the State of South Dakota to update the findings of their original 2007 evaluation of long term care options for South Dakota. The 2015 report includes up-to-date data collected since the release of the 2007 report when Abt Associates was originally commissioned by the Department of Social Services to assess and evaluate the State's long term care system. The following tasks were performed using up-to-date data collected since the release of the prior report: 1) updating demographic trend challenges; 2) updating service delivery challenges; and 3) projecting future demand for long term care services.

In the 2007 report, Abt Associates projected a sharp increase in the demand for long term care services in South Dakota, driven by an increase in the number of individuals and disabled

individuals over age 65. In particular, Abt Associates had previously anticipated an increase of roughly 100,000 elders between 2000 and 2025, paired with an increase of 50,000 or slightly fewer disabled elders over the same time period. The below graph shows actual population totals for 2000-2010 accompanied by updated population projections through the year 2035.

Projections of South Dakota's Elderly and Disabled Population (2000-2035)

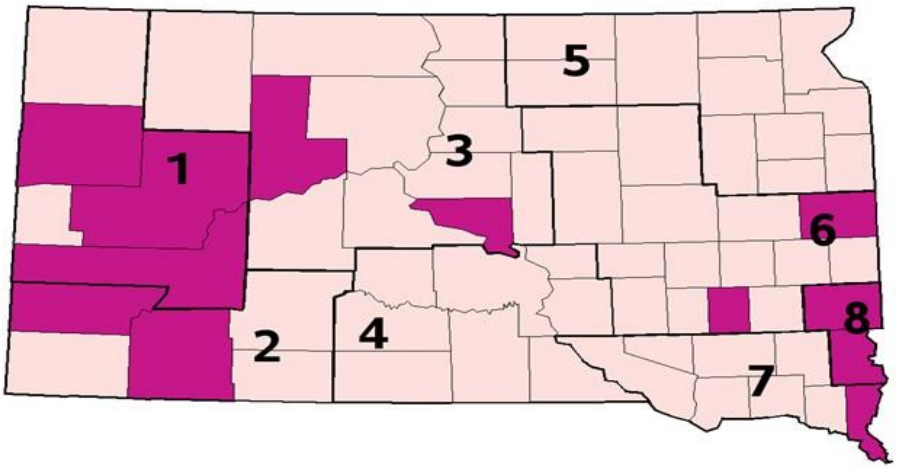


Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data, 2010 and American Community Survey.

Through the 2010 decennial Census, actual growth in the elderly and elderly disabled populations was somewhat lower than projections in the prior report. Accordingly, the South Dakota State Data Center has revised projected growth rates modestly downward since that time. Based on the 2015 report's revised estimates, Abt now projects that:

- The number of elders (over age 65) will increase by about 84 percent in the year 2035 relative to decennial Census totals in the year 2010, increasing by approximately 103,000 to 226,000.
- The number of disabled elders will peak in 2030, increasing by about 33,000 to 85,000, or 71 percent higher than the decennial Census year 2010 total; by 2035, this number will fall slightly as the relative proportion of younger elderly individuals (aged 65-74) increases in relation to the proportion of older elderly individuals (aged 75+).

South Dakota Counties Where Elderly Population is Expected to Double from 2010 to 2035 (in Dark Pink)

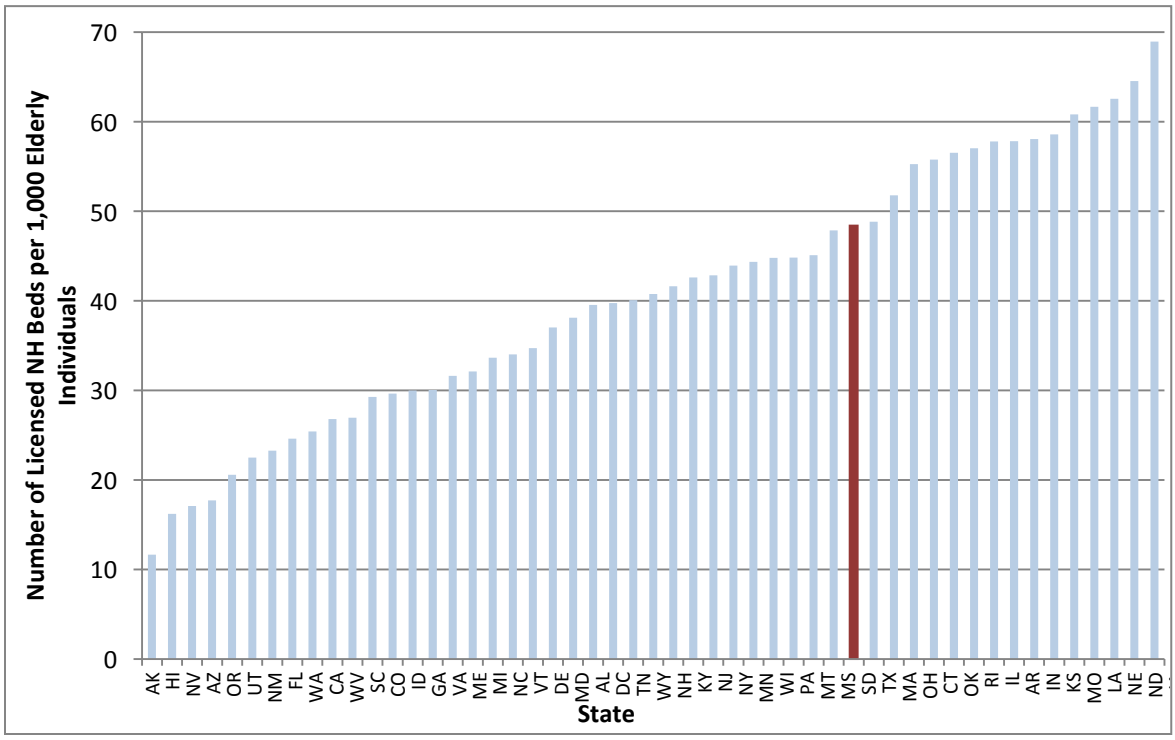


Source: Abt Associates' analysis of South Dakota Data Center's Population Projections data.

Local long term care services will be stressed both by growth in the numbers of seniors as well as by high rates of growth in demand for care. The above map highlights counties where the population of seniors is expected to more than double between 2010 and 2035. Overall, the geographic variation in growth rates across Economic Assistance Regions in this updated report is similar to that seen in the prior report.

Nursing home capacity and utilization rates have continued to drop both in South Dakota and nationwide since the release of the prior final report. In 2006, the most recent data available for the prior report, South Dakota ranked tenth in the nation in terms of nursing home capacity, with 61 licensed beds per 1,000 elders. By 2011, that number had dropped substantially to 48 licensed beds per 1,000 elders, sixteenth nationwide. Though South Dakota's capacity remains higher than national averages, the drop between 2006 and 2011 indicates that the gap is shrinking.

National Comparison of State Nursing Home Capacity, 2011



Source: Abt Associates' analysis of Henry J. Kaiser Family Foundation's Nursing Home Beds data and American Community Survey data. South Dakota utilization rates appear in red.

The updated study identified that further efforts would be required to meet future demand for long term care services outside the nursing home setting. The report concluded that recent policy changes have successfully accelerated the decline in nursing home utilization, reducing the gap relative to national utilization rates. Assisted living utilization has increased in parallel; however, skilled Medicare home health and home and community-based services remain at similar, relatively low levels as noted in the 2007 report.

These results naturally lead to speculation on how the needs of individuals are being met in light of decreasing nursing home utilization without a correlating increase in the use of formal supports. South Dakota has done well in market penetration for private long term care insurance, potentially indicating one way in which South Dakotans are bridging the gap, and an increased use of informal supports by family and friends may also play a role.

The 2015 Updated Long Term Care Study concluded that the State must maintain its focus on rebalancing the long term services and supports system through: 1) continuing to utilize options counseling through the ADRC to educate consumers and families about community-based care alternatives, in attempts to reduce nursing home admissions; 2) continuing to expand and enhance the availability of home and community-based services and potentially State Plan-funded community-based care; and 3) exploration of the care preferences and knowledge base of elders and their caregivers, as well as gathering more information on the informal support networks that people are utilizing in lieu of seeking assistance from state programs.

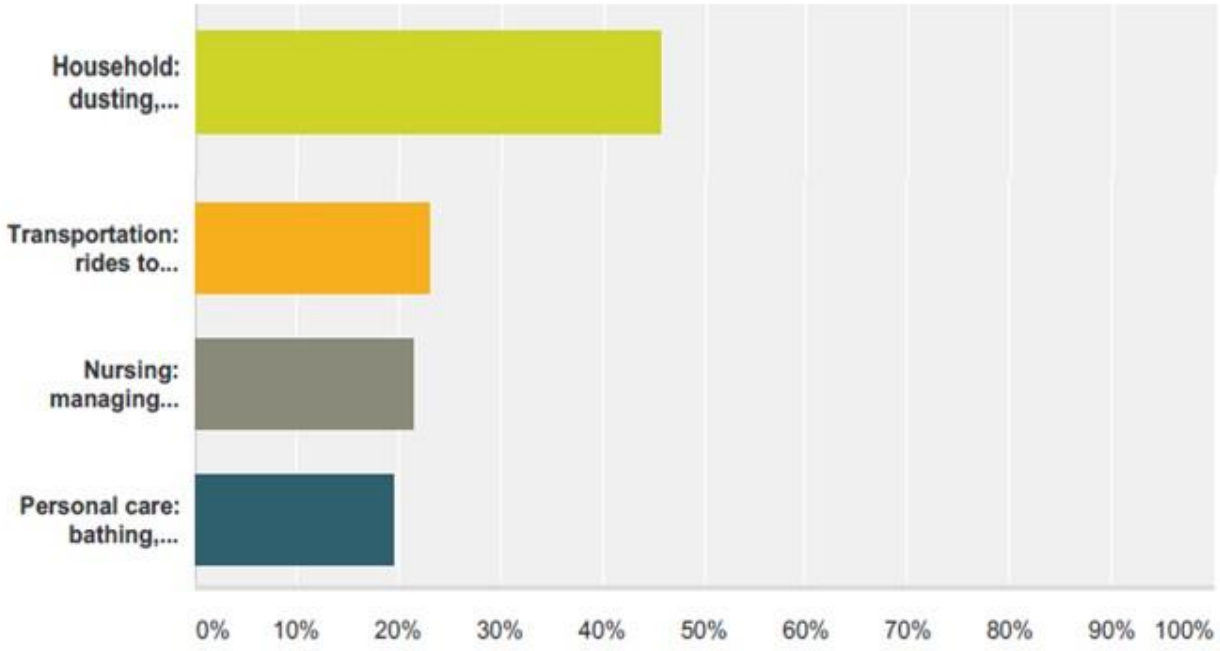
To review the *"Final Report 2015 Evaluating Long-Term Care Options for South Dakota: Update"*, refer to Attachment G

Consumer Survey

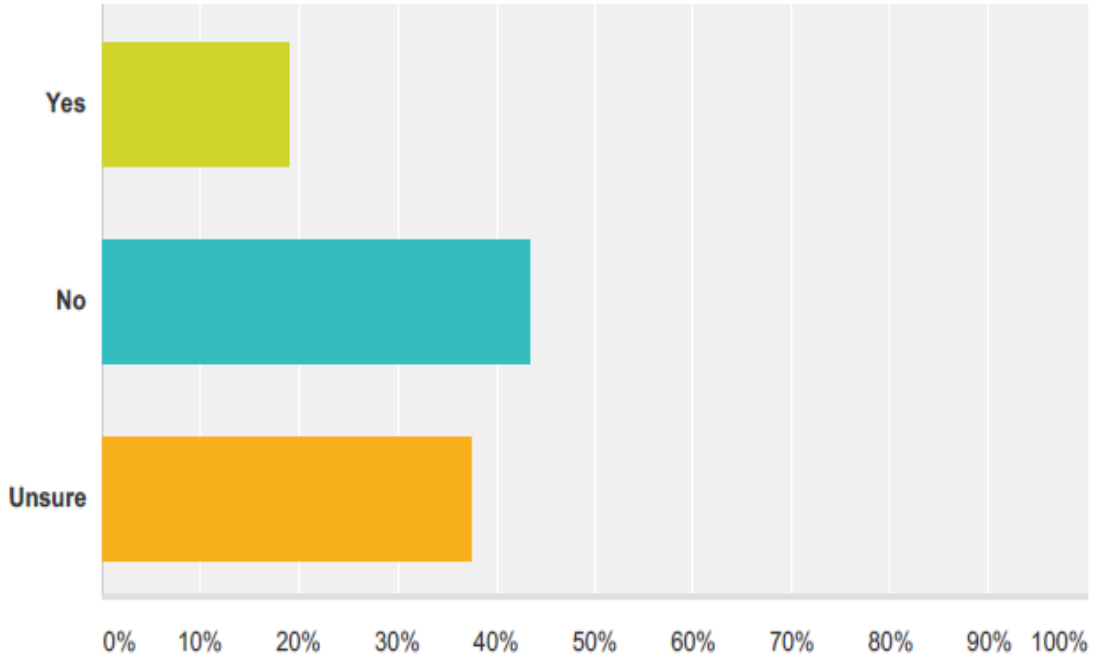
Based on the conclusions of the 2015 study, a Consumer Survey was developed to identify service needs, awareness of services, and to determine what supports consumers were utilizing. 7,500 surveys were distributed via website, mailed to consumers, provided at outreach events and Senior Health Information and Insurance Education (SHIINE) meetings, nutrition sites and senior centers and sent to key stakeholders for distribution. Approximately 1000 responses were received.

The consumer survey took place in July 2015 and revealed that 39% of respondents reported they were not currently receiving services to complete daily living activities. This response could be due to a number of reasons including but not limited to; truly not needing services to remain at home, lacking awareness of services available to support them staying home and increasing their health and safety, and some may not want or feel they need to access public services at this time. Almost 28% of these individuals indicated that at least one service listed would help them remain in their home. For the other 61% of survey respondents, the results showed that 51% receive household assistance such as vacuuming, doing dishes, cooking, laundry, and shopping; 24% get rides they need to appointments and community events; 24% receive nursing services for managing medications, monitoring health statuses, conducting physical assessments and providing routine care; and 20% benefit from personal care services such as bathing or dressing. Services provided were supported through Department programs, paid privately, or by informal supports through family and friends. When individuals receiving services were asked if they could remain at home without their current services, the majority (79%) responded no or that they were unsure. The results of the consumer survey response reflect a need for enhanced awareness of the supports that enable a person to remain safely and happily in their own home long term.

Current In Home Assistance Received



Without Services, I could Remain at Home



ASA Home and Community Based Services Workgroup

The results of the Consumer Survey were used to inform next steps relative to the Adult Services and Aging Home and Community-Based Services (ASA HCBS) Workgroup that convened as a result of the Medicaid Solutions Workgroup and the 2015 updated study conclusions and the recommendation to expand and enhance home and community-based

care. The ASA HCBS Workgroup's focus was on rebalancing the long term services and supports system across the continuum of care. Identified goals of this workgroup were to evaluate barriers to Medicare skilled home health utilization and increase availability of home and community-based services and supports. Stakeholders including in-home providers, long term care providers, government agencies, representatives of South Dakota Association of Healthcare Organizations, South Dakota Health Care Association, Advisory Council on Aging, legislators, and other interested parties met three times from May through August, 2015.

The ASA HCBS Workgroup had four recommendations. One recommendation was to provide education and training to health care practitioners regarding reimbursement availability for physician oversight of Medicare skilled home health services and support and education on the reimbursement request process.

A second recommendation of the Workgroup was to conduct additional research, including fiscal impact of expanding Home and Community-Based waiver services to include day habilitation, vehicle modifications, non-medical transportation, assistive technology, community transition services, chore services, and training and counseling services related to live in caregivers. The workgroup recommended that once the analysis was complete, the Department of Social Services should initiate the waiver application/approval process which must be approved by the Centers for Medicare and Medicaid Services (CMS). Additionally, an expansion of the waiver services would require an appropriation which must be approved by the legislature. In order to further analyze these services and determine how to prioritize implementation of the services, in-home providers and state department staff completed a survey.

This recommendation and follow up surveys of staff and providers resulted in proposed changes to the Home and Community-Based Services Waiver operated by the Division of Adult Services and Aging, now Long Term Services and Supports. The changes in the waiver renewal application included the addition of chore services; expansion of the specialized medical equipment definition to include assistive technology; increased maintenance needs allowance for in-home consumers to ensure consumers can meet their financial obligations and remain at home i.e. rent, utilities, etc.; and increased earned income allowance for consumers residing in an assisted living center by an additional $75. The Department anticipates adding non-medical transportation services, vehicle modifications and community transition services through a waiver amendment in the future but further analysis will need to be completed.

The third recommendation of the Workgroup was to enhance awareness and understanding of the Aging and Disability Resource Connections (ADRC) process through presentations and education. Staff members continue to present information on ADRC Call Centers, information and referral, options planning services available, and assistance to access home and community-based services.

The final recommendation of the Workgroup was to review the current ADRC process, and work with home health providers and targeted consumer groups to ensure smooth transitions for individuals between hospital and home by enhancing the Hospital Discharge Referral Protocols that were developed by Adult Services and Aging (now Long Term Services and Supports) staff and the ADRC Workgroup Partners. As a result of this Workgroup recommendation, the ADRC Hospital Discharge Referral Protocol document was updated and shared with hospital and clinic staff to assist with the transition process. Additionally, effective FY 2017 in-home providers are

required to communicate any hospitalization that they are aware of regarding an ASA consumer, to the Division of Long Term Services and Supports.

Long Term Services and Supports Enhancement Workgroup

During the spring of 2016, the State of South Dakota convened a Long-Term Services and Supports Enhancement Workgroup to focus on the need to re-evaluate its Long-Term Services and Supports system. Staff in the Departments of Human Services, Social Services and Health held regular meetings to enhance and expand home and community-based services options, which will reduce the need for institutional services. South Dakota will continue its efforts to rebalance long term services and supports through providing the necessary services to serve individuals where they want to live and in the least restrictive environment possible. The State of South Dakota is prioritizing its efforts to implement a coordinated diversion effort to minimize new long term care resident admissions and transition current residents to the home and community.

Waiver Renewal

In November, 2016, the Home and Community-Based Services Waiver Renewal Application was approved with a retroactive date of October 1, 2016. With the Waiver approval, several additional services including adult day services, adult companion services, specialized medical equipment, specialized medical supplies, nutritional supplements and nursing services became available to consumers who reside in an assisted living center. Additionally, consumers residing in an assisted living center who work are allowed to keep up to $75 in addition to their personal needs allowance. Consumers who live at home are able to access assistive technology equipment and chore services such as lawn mowing and snow and ice removal from sidewalks and driveways. These services are based on assessed need and must be authorized by an Adult Services and Aging Specialist.

Workgroups with Public Testimony

Recommendations from the Medicaid Solutions Workgroup, Adult Services and Aging Home and Community-Based Services Workgroup, Elder Abuse Task Force, and the 2017 Legislative Committees were also appropriately incorporated into the State Plan on Aging for FY2017 – FY2021. These meetings are all open to the public and advertised via news tips and on the Department's webpage. Members of the audience are provided an opportunity to comment and provide suggestions for future planning.

Legislative Interim Committees

A 2016 Legislative Interim Committee convened to study payment methodologies for Medicaid providers. The scope of this Interim Committee was to assess existing payment methodologies for Medicaid providers to determine adequacy of payments that will provide for long term continuation of services and conclude with recommendations for any changes. The Payment Methodologies for Medicaid Providers Interim Study Committee did not adopt any legislation, but did make the following recommendations to report to the Legislature's Executive Board. For the 2017 Legislative Session, the Joint Committee on Appropriations should: 1) Identify dollars needed to sustain providers to continue to provide services; 2) Find potential funding for sustainability of programs; and 3) Realign expenditures to meet the short-term and long-term needs of the Medicaid population. In addition, when executive branch departments determine reimbursement rates for Medicaid, they should use 2015 cost reports and factor in the updated rule from the Fair Labor Standards Act.

Another 2016 Legislative Interim Committee convened to study regulation of nursing and assisted living beds. The scope of this Interim Committee was to study the benefits, merits, and negative impacts of regulating the number of nursing and assisted living beds in South Dakota and further recommend action that may include elimination of or revisions to regulations for the betterment of the South Dakota populace. The Committee reviewed and received public testimony on seven legislative drafts and voted to introduce five drafts. Legislation adopted by the Committee includes: 1) An Act to require the Department of Health and Department of Social Services to make an annual report to the Legislature regarding the condition of long-term health care in South Dakota. The proposed legislation would require both the Department of Health and Department of Social Services to provide a written report and testimony to the House and Senate Health and Human Services standing committees. 2) An Act to allow nursing facilities to transfer or sell nursing bed capacity. The proposed legislation would allow for a nursing facility to transfer nursing bed capacity to another facility. A licensed facility may also sell nursing bed capacity to another facility. The legislation also provides that any transferred or purchased beds must be licensed within twenty-four months of the transfer or sale by the receiving facility, have a minimum level of Medicaid census and be involved in home and community-based care. 3) An Act to revise the review for additional nursing facilities or nursing facility beds and to require a report to the Legislature. The proposed legislation requires the Department of Health and Department of Social Services to annually consider the need for additional nursing facilities and beds. The legislation also provides for the Department of Health and Department of Social Services to report to the standing committees of Health and Human Services and report on the additional redistribution of health facility beds and additional new nursing facilities. 4) An Act to allow for the redistribution of unused nursing facility bed capacity. The proposed legislation allows any nursing facility to use any unused bed capacity by July 1, 2018 or the unused bed capacity reverts back to the Department of Health. A nursing facility has until July 1, 2023 to submit a proposal to use all or a portion of the unused bed capacity previously held by the nursing facility. 5) An Act to establish a program to assist nursing facilities and assisted living facilities in recruiting certain health care personnel. The proposed legislation provides for a program to assist nursing and assisted living facilities in recruiting registered nurses, licensed nurses, nurse aides, and medication aides. No more than sixty registered nurses, licensed nurses, nurse aides, and medication aides can participate in the program each year. The legislation also provides for an incentive payment which would give ten thousand dollars to licensed and registered nurses, five thousand dollars to nurse aides and two thousand-five hundred dollars to medication aides.

Provider Capacity Workgroup

The Departments of Social Services, Human Services and Health have worked together leading the effort to enhance long term services and supports in South Dakota. As part of this effort, a Provider Capacity Workgroup convened in February, 2017 to look at provider capacity challenges in South Dakota. The purpose of the workgroup is to find solutions that will ensure South Dakotans who are elderly or disabled receive services in the most integrated and least restrictive community setting and have a choice of providers and services that provide meaningful outcomes.

Reorganization and Creation of the Division of Long Term Services and Supports

During the 2017 Legislative Session, Governor Daugaard signed an Executive Order to create the Division of Long Term Services and Supports within the Department of Human Services. The Division of Adult Services and Aging, the State Unit on Aging, within the Department of Social Services and Assistive Daily Living Services Program within the Division of Vocational

Rehabilitation in the Department of Human Services were combined into the new Division of Long Term Services and Supports. This reorganization was effective April, 2017. This transition created a more integrated approach to long term services and supports delivery in South Dakota. Demographic changes in future years will result in significant increases to the elder and disabled elder populations. Today, people with physical disabilities who need state assistance with long term services and supports receive services through the Department of Human Services. People with age-related or other qualifying disabilities get assistance from the Department of Social Services. Combining these services into one Department helps ensure that people can best access long term services in their homes and communities, regardless of why they need the services or what type of disability they have. Additionally, this change aligns services available for individuals, and helps facilitate continued development of community-based services for people in our state, benefiting the citizens of South Dakota.

Through a series of workgroups and other initiatives, South Dakota has identified challenges facing the state in upcoming years. We have taken, and continue to take steps toward the goal of meeting those challenges. South Dakota will continue to work with providers to enhance available services for individuals in community settings. Monitoring of numbers related to consumers on waivered services, Money Follows the Person initiative, state-funded assistance programs, and nursing facility utilization, will provide evidence of the state's commitment to meeting the identified goals. South Dakota will continue the effort to expand and enhance existing home and community-based services to ensure services are comprehensive and meet the needs of elderly citizens in South Dakota.

The State of South Dakota is committed to assuring older South Dakotans receive a seamless, comprehensive service system, responsive to their individual needs and preferences. This State Plan on Aging will serve as a roadmap and guide for the State of South Dakota to embrace a long term services and supports system that ensures elders and adults with disabilities are provided with the necessary services and supports to allow them to live where they choose and in the least restrictive environment possible. These services and supports will be provided throughout the continuum of care to assist older South Dakotans and adults with disabilities to live to their full potential.

State Plan Available on Website

In preparation for the 2017 –2021 State Plan on Aging, the Division of Long Term Services and Supports sought comments to the State Plan on Aging which ends September 30, 2017 by posting the 2013 –2017 version on the website following approval by the US Department of Health and Human Services Office of the Assistant Secretary, Administration on Aging. The State Plan on Aging is available on the Department's website and the public has been encouraged to provide comments and suggestions for future planning. A draft of the 2017 – 2021 State Plan on Aging was also made available on the Department's website and the public was again encouraged to provide comments and suggestions to help frame the State Plan on Aging.