

The Dual Challenge

***Preserving Services for
the Oldest Old Today;***

Planning for the Elderly

Baby Boomers of Tomorrow

Area 4 Agency on Aging

*Serving Nevada, Placer, Sacramento,
Sierra, Sutter, Yolo and Yuba Counties*

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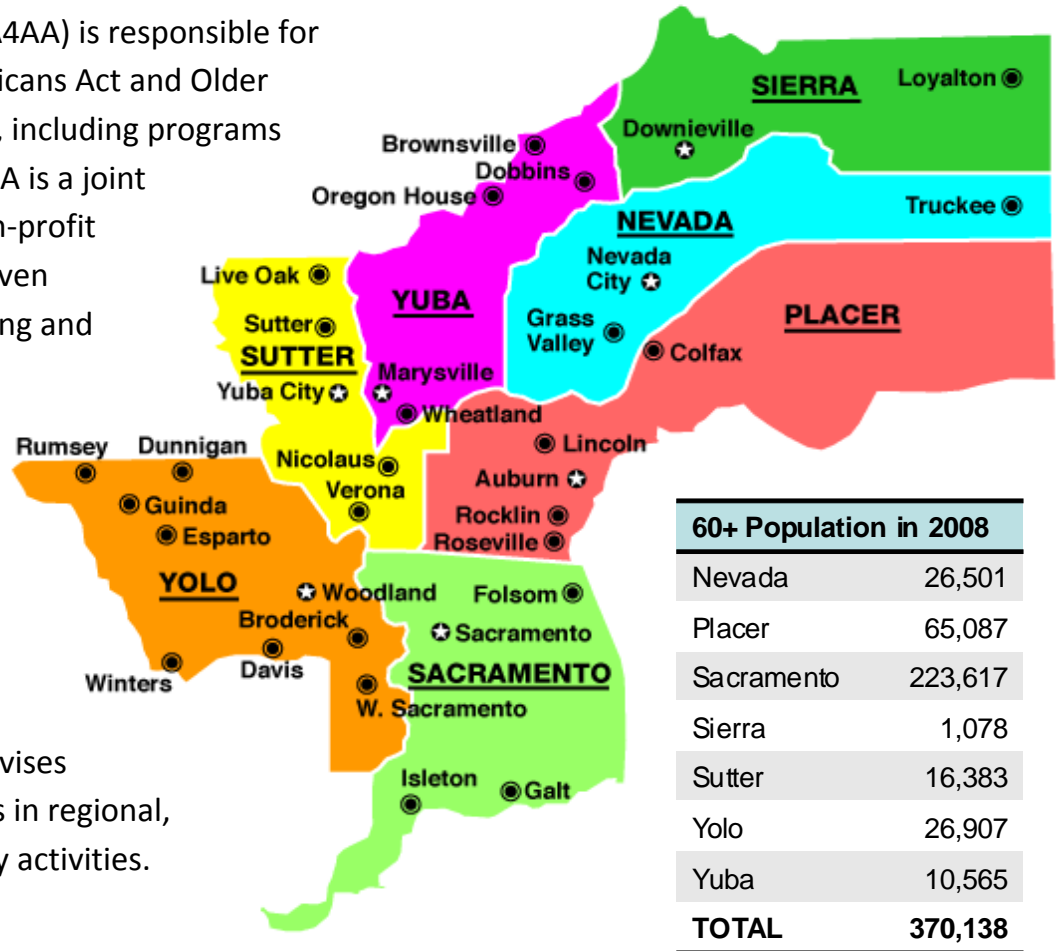
***Planning for the Elderly
Baby Boomers of Tomorrow***

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*Serving Nevada, Placer, Sacramento,
Sierra, Sutter, Yolo and Yuba Counties*

Area 4 Agency on Aging

Area 4 Agency on Aging (A4AA) is responsible for administering Older Americans Act and Older Californians Act programs, including programs for family caregivers. A4AA is a joint powers authority with non-profit status. We serve these seven counties (known as Planning and Service Area 4). Our 17 member Governing Board is composed of County Boards of Supervisors or their appointees. A4AA also benefits from an independent 35 member Advisory Council which advises the Board and participates in regional, state and federal advocacy activities.



The Dual Challenge: Preserving Services for the Oldest Old Today; Planning for the Elderly Baby Boomers of Tomorrow

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Classrooms all across America were filled to capacity with Baby Boomers by the mid-1950s.

Today, five decades later, the eldest members of this generation are beginning to crowd into Social Security offices to apply for retirement benefits.

Foreword

By Lynn Daucher

Director, California Department of Aging



Congratulations to Area 4 Agency on Aging for facing the future. A dramatic shift in California's population approaches as the bubble of aging baby boomers flows forward in time. By 2020 California's population over 60 years old will increase to 20% from its current 14%. Not content to wait passively for this aging tidal wave, Area 4 boldly began studying statistics, projecting possible impacts and charting a calming course through the coming turbulent decades.

The demands of a new generation of seniors determined to age in place and determined to fiercely guard their independence will challenge our current system of services. Insuring transportation for new non-drivers, retrofitting housing stock for wheelchairs and walkers and finding friends and family to help in the home or finding funding for such services will put pressure on our unprepared communities.

The Area 4 Agency on Aging is planning to be prepared. Its Baby Boomer Study sets the stage for strategic planning. I encourage everyone to engage and collaborate in shaping this strategic plan. California's future depends on you.



About this Report

In 2006, Area 4 Agency on Aging began to investigate the question of how, specifically, the aging of the Baby Boomers might impact our seven county service area, which includes Nevada, Placer, Sacramento, Sierra, Sutter, Yolo and Yuba Counties. To help with the effort, the Agency recruited local experts on the subject (see page ii for a listing of the community contributors). Along with Area 4 staff, Advisory Council and Governing Board members, this “Boomer Workgroup” convened in January of 2007 and met regularly for a period of eighteen months.

The goal of this group was to take a first step toward a better regional understanding of the “Aging Boom” so that the entire community could begin to prepare for the imminent influx of older adults in an informed and organized fashion (the term “Aging Boom” refers to an increase in the average age of the population brought on primarily by the aging of Baby Boomers). Thus the intended audience of this report is local leaders in the public and private sectors as well as professionals already working in the aging services field.

In producing *The Dual Challenge*, we drew inspiration from a number of valuable reports and studies that had come before. Assemblywoman Patty Berg’s *Building an Aging Agenda for the 21st Century* provided a conceptual foundation. The American Hospital Association publication entitled *When I’m 64* offered insights into how to present projections into 2030. Reviewing *The Future of Aging in North Carolina* was helpful because the need to provide public services is the underlying theme. And, an Institute for the Future report called *Fault Lines in the Shifting Landscape* was the basis for our recommendations section (Part Six); sadly, many of the issues they raised in 1999 remain unaddressed today.

Much of the original data compiled for *The Dual Challenge* was drawn from the latest California Department of Finance population projections (July 2007). This rich data set made it possible for us to isolate generations and perform county-level analysis. We are also indebted to the work of the Urban Institute from which we adapted several data models that yielded logical and credible figures through the year 2040. Lastly, the release of the Elder Economic Standard helped legitimize and crystallize our idea of the Assets-Ability Matrix (presented in Part Four).

In the spring of 2008, eighteen local people with special knowledge of aging issues reviewed our working draft of the report (see Acknowledgements page for a listing). Based upon their feedback, the document was extensively reworked and revised, ultimately becoming the product you see today.

In sum, we feel *The Dual Challenge* provides compelling information which can leave the reader with no doubts about the scale and potential severity of rapid population aging in our region. At the same time, the Conclusion offers the encouragement that innovative solutions are within our grasp. It is our hope that this report will act as a catalyst for continuing discourse, planning and advocacy around this critical issue.

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Introduction

In essence, Area 4 Agency on Aging exists to help older people live as independently as possible for as long as possible, with safety and dignity. Independence for most means continuing to live in their own home (as opposed to a care home). Our Agency and others like it augment the needs of frail individuals and those who care for them through the provision of home and community-based services. Ultimately, one’s ability to remain independent at an advanced age is a matter of preparation, health and financial security.

As we look at the road ahead, we are gravely concerned about our ability to fulfill our mission. Chronic federal and state budget shortfalls have forced us to reduce services, even as our frail elderly population is growing exponentially. At the same time, the massive Baby Boom generation has begun their rather reluctant shift into senior citizenship. Though there appears to be some enthusiasm about re-tooling services for Boomers, we worry those efforts may draw focus and resources away from the oldest old who need assistance now and for many more years to come. In our seven county region, the number of people in the vulnerable 85 and older age group will double before America’s first Boomer celebrates her 85th birthday.

The research that led to this report was motivated by a simple question: How will the aging of the Baby Boomers affect the local aging services network? Our efforts to answer that question required that we review projected data about the future and led us to examine measurable differences between generations, particularly in the areas of health and economics. With respect to the former, we have sought out and utilized the most credible sources available. With respect to the latter, we found significant variation between generations on most points. In some cases, the difference could be attributed to the normal aging process; in others, it was correlated with historical trends or developments.

There are three distinct generations of senior citizens in the United States today. They are the Traditionalists (those born between 1900 and 1935 – many of whom parented Boomers), the Pre-Boomers (those born during the WWII period) and the Baby Boom Generation (born during the years following WWII). In 2025, Generation X (those born between 1965 and 1980 – most of whom are children of Boomers) will enter older adulthood, adding a fourth group to the mix. For reference, the chart below shows how old the members of each group will be at 10-year intervals.

America's Generations	Age in 2000	Age in 2010	Age in 2020	Age in 2030	Age in 2040
Traditionalists (born 1900-1935)	65-100	75-110	85-120	95-130	105-140
Pre-Boomers (born 1936-1945)	55-64	65-74	75-84	85-94	95-104
Baby Boomers (born 1946-1964)	36-54	46-64	56-74	66-84	76-94
Generation X (born 1965-1980)	20-35	30-45	40-55	50-65	60-75

The **Traditionalists** are generally characterized as a hard-working generation (*dubbed the “Greatest Generation” by some and the “Silent Generation” by others*) who grew up during the Great Depression, survived World War II, had plenty of children, and built the country into a world power.

The **Pre-Boomer Generation** refers to those who grew up during America’s transition from the high expectations of the 1950s to the more turbulent era of the 1960s, including the Kennedy assassination. They tend to identify more strongly with the Baby Boomers than with the Traditionalists but have characteristics of both groups.

The **Baby Boomers** were, at the time, the largest generation of Americans ever born. They are also a uniquely tight cohort^a, bound together by a television-propelled sense of popular culture and by the shared experience of compelling social events, such as the Vietnam War.

The Baby Boomers are complex to study because they are a polarized group. A certain portion of them are among the healthiest, wealthiest older people the nation has ever seen. But as a group, Boomers are also *less* healthy and *less* economically secure than their parents were a generation earlier. The sheer size of this graying group (which totals about 524,000 people in our region) has attracted the term “Silver Tsunami.”

Many people believe that Boomers will be different kinds of seniors than their parents. In particular, Boomers, as a group, tend to have values, beliefs and expectations which clash with the “traditional” senior

experience. The Boomers, they say, will want their golden years to be active, challenging, and meaningful. In truth, the stereotypical image of sleepy, silver-haired elders spending their days in rocking chairs has been outdated for some time. By all accounts, however, the Boomers’ transition into the “golden years” will color every facet of American life.

In sum, it is abundantly clear to us that the local aging services network should be expanding services to prepare for the great increases in demand, yet we are moving backwards. If we continue on our present course, the aging network will be under water long before the “wave” of Baby Boomers ever arrives. Under that scenario, the responsibility of meeting the personal care needs of all surviving Boomers in 2030 (roughly 470,000 of them) would fall entirely on family members and the community at large.

This unprecedented social challenge cannot be met unless all key stakeholders from the public and private sectors come together very soon and act decisively. The aging of the Baby Boomers will put our fragile system of benefits and service for older people to the ultimate test.

Traditionalists



Childhood



Adolescence



Work



Retirement

Baby Boomers





Executive Summary

The population of older Americans is growing and changing at an unparalleled rate, and the potential implications are profound. The aim of this report is to describe how the senior demographic is evolving here in the seven county Sacramento-area region known as Planning and Service Area 4 (PSA 4), to explain the sobering challenges this poses to the local aging services network, and to offer recommendations for appropriate community action.

Part One: The Rapidly Changing Face of Our Older Population

The rapid growth of the senior population in our area is primarily due to natural aging among members of the unusually large Baby Boom generation. Their “arrival” into the ranks of senior citizenship assures, among other things, a more ethnically diverse senior population. Increasing longevity is also an important contributor to overall population aging. In fact, centenarians (people 100 years and older) are the fastest growing group. Key findings^b from Part One include:

- 1) The 60 and older population will nearly triple between 2000 and 2040.
- 2) There will be a five-fold increase in the 85+ population between 2000 and 2040.
- 3) The number of people 100 and older will increase by a factor of fifteen by 2040.
- 4) Most Baby Boomers (over 54%) will live to age 85, and about 21% will live to age 95.
- 5) The *proportion* of Hispanic/Latino seniors (the fastest growing ethnic group) will nearly triple between 2000 and 2040 (from 7% to 20%).

Part Two: Changes in Older Adults’ Health

For now, growth in the senior population is being accompanied by a proportional growth in the number of persons with disabilities. In the future (when the eldest Baby Boomers reach age 80 in 2025), the disability rate is expected to accelerate. Again, natural aging and longevity are the principle factors. Key findings^b from Part Two include:

- 1) In the year 2000, roughly 90,000 people 65 and older in our region had some type of disability. Some 40,000 had a “going outside the home” disability, suggesting they rely on others for transportation. Nearly 20,000 had a “self-care” disability, which likely means they require help with daily activities.
- 2) The near tripling of the senior population will translate into a near tripling of the number of older persons with functional limitations between 2000 and 2040.
- 3) In our region, as many as 25,000 people may have Alzheimer’s disease.
- 4) About 2,000 Traditionalists (1.9%) reported feeling downhearted all the time. The top concern that working family caregivers in the area have is that their loved ones will be sad, lonely or depressed.
- 5) Approximately 29,000 Traditionalists (17.5%) are clinically obese today, and 16% have either Type I or Type II diabetes. By 2030, one-third of all Baby Boomers in the nation are projected to be obese, and 25% of Boomers are expected to be living with diabetes.

Part Three: Changes in Older Adults' Financial Standing

The Pre-Boom and Baby Boom generations are now moving into retirement with higher rates of poverty, as a group, than the Traditionalists did. A falling federal poverty rate for seniors mitigates the effect from a statistical standpoint, but not in real terms for those who struggle to make ends meet. Key findings^b from Part Three are:

- 1) By 2020, fewer than 18,000 seniors age 62 and older will fall below the federal poverty level, but over 42,000 will experience *relative* poverty. Federal statistics show that 40 percent of seniors would immediately fall into poverty if they stopped receiving their Social Security check.
- 2) According to the Elder Economic Security Standard Index for Sacramento County, an average elder couple paying a mortgage must earn \$36,733/year to cover their basic living expenses. The average single elder renting a one-bedroom apartment needs to earn \$21,517/year to cover their costs.
- 3) In our region, 8.9% of Traditionalists (then age 70+), 36.6% of Pre-Boomers (then age 60-69) and 75.2% of Baby Boomers (including those then age 45-59) were in the labor force in 2005.
- 4) Medical bills are cited as the number one reason families are forced to declare bankruptcy. Roughly 46,000 Baby Boomers have no health insurance.
- 5) As of June 2008, the median price for a home in Sacramento County was \$219,500. Values have plummeted by 41.3% since the last high point in August of 2005.

Part Four: Estimating Overall Need and Service Demand

In order to estimate how many older adults may need assistance to live independently, A4AA has developed a risk measurement tool called the Assets-Ability Matrix. The tool is centered upon the simple idea that seniors come to need services as a result of a health issue, an economic issue, or both. Forecasts for the demand for skilled nursing and in-home care are also presented. Key findings^b from Part Four include:

- 1) Almost 8,000 people age 65 and older have low physical ability and low financial assets, placing them in the category of those with the highest risk of become dependent on others. Over 30,000 additional seniors are classified as having a "high" risk of dependency.
- 2) Less than one-third of people 65 and older (31.5%) are currently "safe" from the chance of becoming dependent on others; they are in the lowest risk category.
- 3) Although the rate of nursing home utilization is expected to remain fairly stable (at around 12.5% nationally), population growth in our area will cause a tripling in the number of persons in nursing homes between 2000 and 2040.
- 4) The number of frail individuals receiving paid care is expected to increase the fastest. By 2040, more individuals are expected to be receiving paid care than unpaid care.

Part Five: Limitations of the Aging Services Network

The national aging network has been consistently under-funded, yet forced to address a widening body of needs. In California, the network has never been well organized, leading to inefficiency. As a result, the local aging network is poorly prepared to address the dual challenge. Key findings^b from Part Five include:

- 1) Today, there are over a dozen state agencies offering more than 125 different programs to older Californians, each with varying regulations and eligibility restrictions.
- 2) In California, there is 1 geriatrician for every 4,000 people 65 and older. In contrast, there is 1 pediatrician for every 1,219 children in the state.
- 3) The total cost of long term care (including in-home, assisted, and skilled nursing care) in the year 2000 was \$120 billion; 59% was financed through government sources, 1% was financed by private insurance companies, and 40% of the cost was paid by individuals and families.
- 4) Beginning in 2017, Social Security benefit payments will exceed revenues for the first time, and a complete depletion of resources is projected by 2041. This year (2008), Medicare benefits will exceed revenues, condemning the program to expend its last dollar by 2019.

Part Six: Recommendations for “Demographic Preparedness”

The final chapter of the report draws an analogy between preparing for a natural disaster and preparing for a potentially devastating demographic event. Seven local organizations are profiled as examples of creative leadership in aging issues. The recommendations from Part Six are:

- **Individuals and Families** should: 1) Adopt and maintain a healthy lifestyle, 2) Revise their retirement plans with longevity in mind, 3) Put together a long term care plan, and 4) Encourage family members to do all of the above.
- **Educators** should: 1) Integrate discussions of older people and age-related topics into K-12 classrooms, 2) Place greater emphasis on the study of aging issues in higher education, and 3) Expand geriatric training for all health care professionals.
- **Local Governments** should: 1) Protect vulnerable elders from abuse, 2) Preserve vital services for seniors, 3) Invest in preventative health care programs, and 4) Encourage all government departments to prepare for an aging community.
- **Primary Health Care Providers** should: 1) Expand services, 2) Place more emphasis on prevention and self-care, and 3) Invest in new technologies that improve access to care.
- **Community-Based Organizations** should: 1) Continue to provide vital services for older adults and family caregivers, 2) Advocate for the needs of their own elder members, and 3) Capitalize on an increasing base of prospective volunteers.
- **Faith-Based Organizations** should: 1) Help their eldest members to continue living in their own homes, 2) Support their elder members who are involved in family caregiving, and 3) Help their members with end-of-life decision-making.
- **The Private Sector** should: 1) Educate tomorrow’s retirees, 2) Support working family caregivers, and 3) Hire older workers.



Every week in our seven county region, about 500 more Baby Boomers celebrate their 60th birthdays, senior citizenship's official starting point. Meanwhile, at the other end of the continuum, the number of centenarians (people 100 and older) is climbing dramatically. These two trends are rapidly changing the size and complexion of the senior demographic as a whole and sparking new ideas about what it means to be old in the 21st century. Part One of this report describes how the local senior population is expected to change over the next several decades and addresses broad implications of those shifts. In short, our senior population will soon be much larger and more multi-faceted than it is today.

A. Population Projections (60+)

We are witnessing a dramatic and unprecedented increase in senior population, and it is driven largely by the aging of the Baby Boomers (shown in red).

By 2040, more than 800,000 people age 60 and older are projected to be living in our seven county region known as Planning and Service Area 4 (see chart to right). This is nearly three times the number of seniors in 2000; it also represents an astounding growth rate of 192% for the forty year period. In comparison, California's expected senior growth rate over those four decades is 170%.

Why is the senior population in our region growing faster than it is statewide? Migration is a significant factor. An influx of retirees and others has caused surges in recent years and is expected to do so in the future. In 2006, Lincoln was the sixth fastest growing small city in California. There, the presence of a relatively new Del Webb community continues to draw a substantial number of older people from the Bay Area and elsewhere in the state.

Other local cities that are growing exceptionally quickly are Live Oak, Rancho Cordova, Elk Grove (also with a new Del Webb development) and West Sacramento.¹

The *proportion* of older people will also rise substantially. In 2000, 15.2% of all local residents were 60 or older; in 2040, it is estimated to be

24.3%.² As a result, senior citizens will play an even greater role in every aspect of society: education, government, health care, community, religion, business and especially the family.



Planning & Service Area 4 (PSA 4) = Nevada, Placer, Sacramento, Sierra, Sutter, Yolo and Yuba Counties
 Traditionalists (born 1900-1935); Pre-Boomers (born 1936-1945); Baby Boomers (born 1946-1964); Generation X (born 1965-1980)

B. Population Projections (85+)

The 85 and older population is of particular concern, for they represent the most frail and vulnerable age group, and they utilize a sizeable share of all elder care services. Here, the situation is even more alarming. The number of elderly people in the seven county region is projected to grow exponentially, resulting in a five-fold increase in frail persons (from about 25,000 to over 125,000).

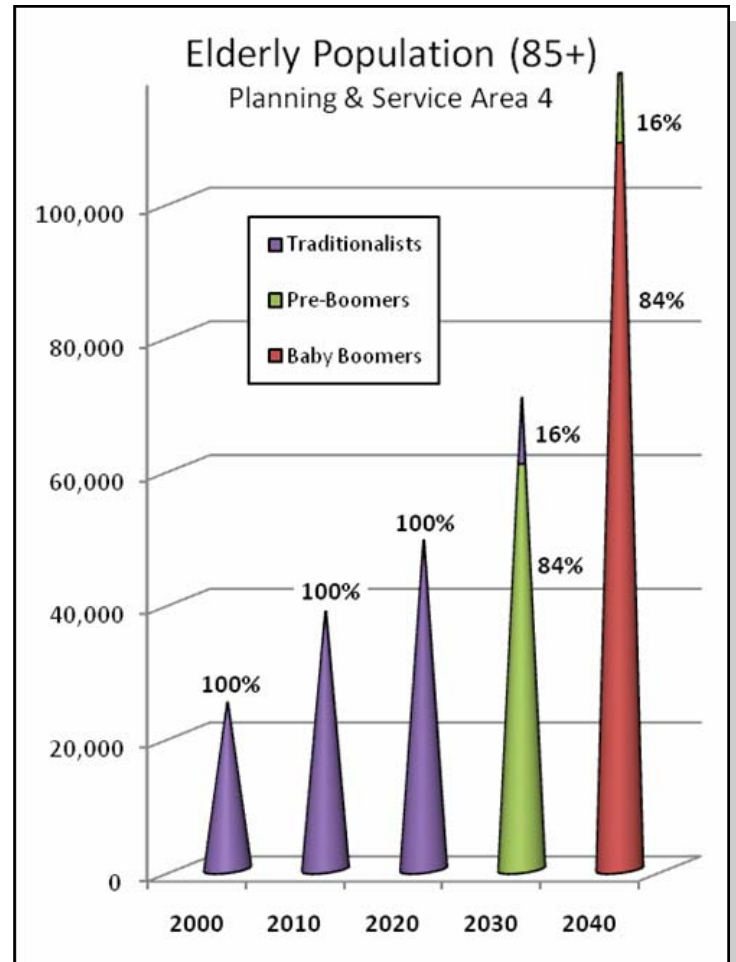
How is this possible? Traditionalists (shown in purple) are living longer than previous generations, and their children (the Boomers) will live longer still. In 2031 the first Boomers will turn 85, causing the elder population to nearly double during the 10 years that follow (shown in red). During this period, the “wave” of elderly Baby Boomers will first reach the shore, and the impact of their “arrival” will be felt most strongly.

When the Baby Boom began in 1946, life expectancy at birth was 66.7 years. According to the Center for Disease Control (2005), a man turning 65 today can expect, on average, to reach age 82, while a woman can plan to see her 85th birthday. Those who do live to age 85 can expect to reach their nineties (91 for men; 92 for women).³

In PSA 4, the Department of Finance data suggests most of the Baby Boomers alive today (54.7%) will live to age 85, and 20.8% of them will live to age 95.

The implications of these trends are epic. In 2030 a fair number of 80 year old Baby Boomers will likely still be caring for their parents who, by then, will be near or beyond 100 years of age.

Sound outlandish? Today, there are an estimated 281 centenarians in Planning and Service Area 4 (PSA 4). By 2040, the Department of Finance projects that over 4,200 people in our area will have been living a full century or longer.² That is an unfathomable fifteen-fold increase!



C. The Closing Gender Gap

Historically, women have significantly outnumbered men in the upper age groups due to differences in mortality rates. Over the next several decades, that gap will become less pronounced. While death rates for older people are evening out between the sexes, another factor is also at work — compared to earlier generations, more men are reaching their 60th birthdays in the first place. Safer conditions on the job are one of many explanations for this.

For the 60 and older population in Area 4, the female majority will drop 1 percentage point from 2000 to 2040 (from 56% to 55%). In the 85 and older segment, the rate will drop much farther over the same period, falling 7 percentage points (from 69% to 62%). In California, the

change will be similar (minus 2% for 60+ and minus 7% for 85+).²

Arguably, the most significant implication of this trend is that fewer women will spend many of their final years as widows. Elderly widows, particularly those who live alone, have historically been a high risk group in terms of needing assistance to remain independent because of the personal, emotional and financial hardships they encounter from the loss of their husbands.

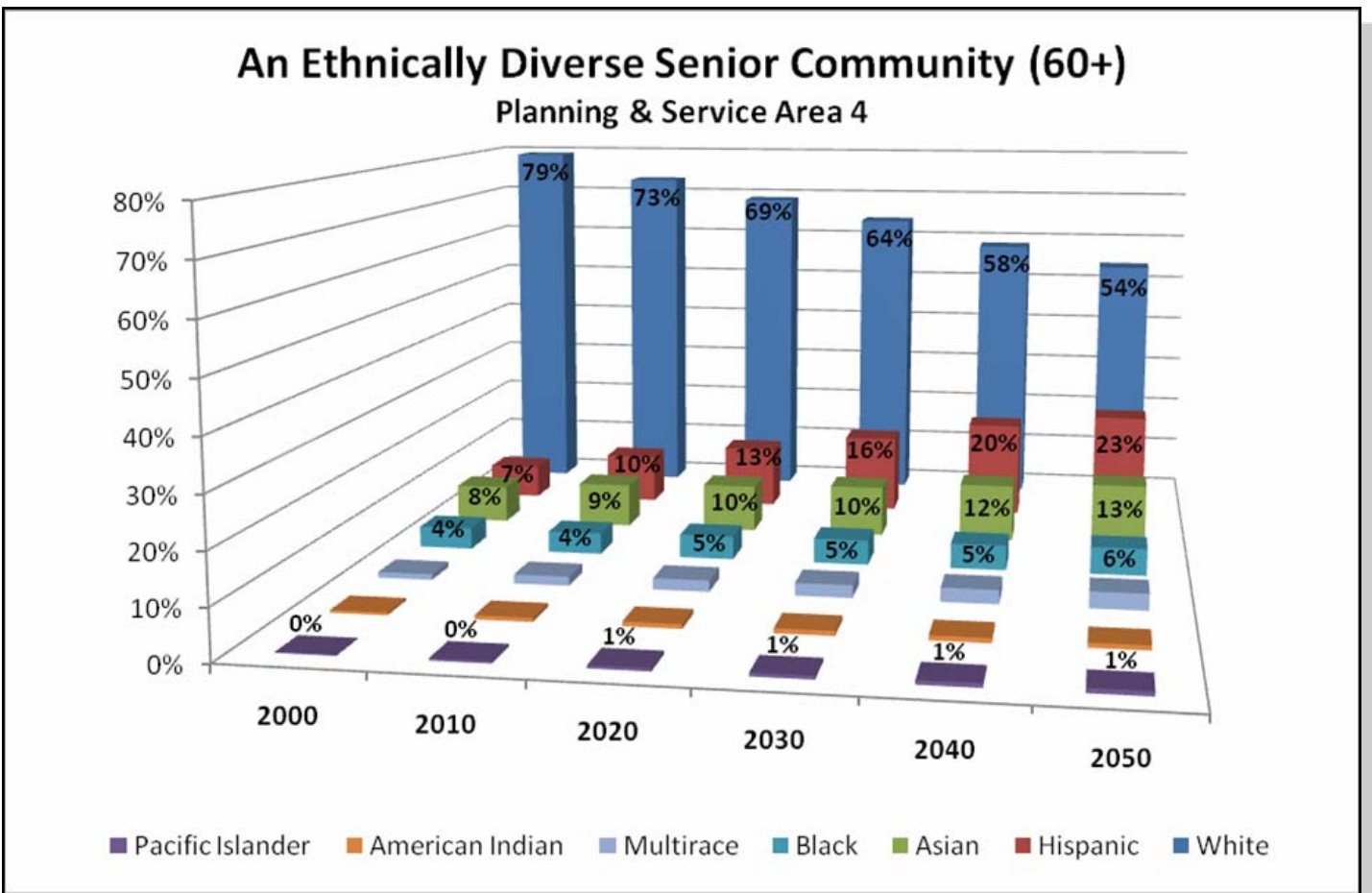
D. Increasing Ethnic Diversity

Over time, successive generations of Californians have become increasingly diverse. This can be attributable to lower birth rates for white families, higher immigration rates for ethnic individuals (new arrivals in our area include Hmong, Indians/Pakistanis and Russians/Ukrainians), and

intermarriage between Caucasians and people of color. As a result, the senior population will be much more diverse in the near future.

Through the year 2040, the *percentage* of older people in every ethnic category will increase (with the exception of American Indians which will remain stable) while the *percentage* of Whites/Caucasians (shown in blue) will fall steadily. The *ratio* of Hispanic/Latino seniors (shown in red), the fastest growing demographic, will nearly triple over that time span; the overall number of seniors in that group will increase by a factor of eight (from under 20,000 in the year 2000 to nearly 170,000 in 2040).²

Interestingly, the *percentage* of persons who have difficulty speaking English is not expected to change significantly.⁴ Nevertheless, greater



ethnic diversity carries substantial implications for long term care. The way care services are delivered in the U.S. today often clashes with traditional, family-centered beliefs that people from many other parts of the world have about how elders should be cared for and who should be providing the care. If we as a community are truly committed to helping *all* older adults live as independently as possible, much more emphasis on cultural competency will be needed in the aging services network in the years ahead.

E. Changing Family Structures

Generational differences are quite evident in comparisons of family structures. Whereas the Traditionalist couple typically married early and remained married for the duration of their lives, Pre-Boomers and Boomers have been much more inclined to have gotten married multiple times or to have foregone marriage altogether.⁵ At the same time, the average family size in America has declined, partly because people have chosen to have children later in life. During the Baby Boom, there were 3.5 children per household. A generation later, the typical Boomer is a parent to just 1.8 children.⁶

The percentage of divorcees in our region is notably higher than is found in the state and nation for all three generations (see chart to the right). Conversely, the proportion of never-married people is generally lower. It is not clear why the Sacramento area would be markedly different from California in either category.

While the overall causes of divorce, non-marriage and smaller families can be debated, the consequences are what concern us here. Traditionalists who raised large families when they were young are well-positioned to have adult children willing to help care for them now that they have grown old. The Baby Boomers themselves had fewer children, and therefore have fewer prospective caregivers. As a result, their eldest sons and daughters (Generation X)

will face a heavier care burden in the future. For those with mixed or extended families, it remains to be seen whether the following generation will respond to the care needs of step-parents and other non-blood relatives. That is an unanswered question with crucial long term care consequences for Boomers.

Marital Status, 2000 Census	PSA 4	CA	US
Divorced			
Traditionalists	9.7%	9.5%	6.7%
Pre-Boomers	18.7%	16.7%	13.9%
Baby Boomers*	17.3%	13.9%	14.2%
Never Married			
Traditionalists	2.8%	4.3%	3.9%
Pre-Boomers	4.4%	6.3%	5.2%
Baby Boomers*	12.8%	14.9%	12.6%

**Includes non-Boomers born in 1965*

Another apparent consequence of the long-time trend away from traditional families is a steady increase in the proportion of grandparents raising grandchildren. When young Pre-Boomer couples began to divorce in the late 1950s, their small children would sometimes land under the care of Traditionalist grandmothers and fathers. That pattern has continued. In the late 1980s, a number of new Boomer grandmas and grandpas first found themselves assuming responsibility for toddlers when young Gen X parents couldn't manage on their own. Of all the grandparents raising grandchildren in California in 2005 (almost 270,000), just 36% were 60 or over; the majority of the others were Baby Boomers.⁷

Hence the “sandwich generation” has already given way to what author Ken Dychtwald calls the “double-decker sandwich generation” as Boomers care for their aging parents and their own grandchildren at the same time. And, he says, “the average 21st century American will actually spend more years caring for parents than children.” (Agenda, September 2006)



Part Two:

Changes in Older Adults' Health

Functioning in later years may be diminished if illness, chronic disease, or injury limits physical and/or mental abilities. Changes in disability rates have important implications for work and retirement policies, health and long-term care needs, and the social well-being of the older population.

Federal Interagency Forum on Aging-Related Statistics
Older Americans 2008: Key Indicators of Well-Being

The Dual Challenge: Disability

Our oldest Traditionalist generation will encounter increasing health problems as they advance in age. By 2020, they will all be 85 and older. If current trends hold, some 36,500 local Traditionalists will have some type of disability by then.

At the same time, Baby Boomers in our region will also face increasing limitations as they grow older. By 2020 (before the first Boomer turns 75), nearly 230,000 members of this generation will have a disability. This is based on the conservative assumption they will be no more prone to disease and chronic conditions than their parents were.

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Just as the senior population is growing in both directions due to natural aging and longevity, the *disabled* senior population is expanding proportionately. Between 2000 and 2005, the number of local residents 65 and older with a disability had a net increase of 11,000 people (about a 12% increase) caused mainly by Pre-Boomers turning 65 *with* existing conditions.¹ The combination of a surging supply of young seniors with health problems and an elderly population growing in size and frailty raises ethical questions about how to divide a limited supply of health and supportive services. Part Two of this report describes how the health status of our senior population is expected to change through 2040. Without question, more people than ever before will be living with disability and chronic disease in the years to come.

A. The Disabled Senior Population, Today and Tomorrow

Defining and Measuring “Disabilities”

A senior citizen’s disability status is the single most important indicator of his or her ability to live independently. Yet, “disability” as a measure is very problematic because it is defined in several different ways, each yielding different results. A person could state that 15%, 31%, or 42% of seniors 65 and older have disabilities today, and they could provide valid sources to support each figure.²

The most frequently cited statistics are those that come from the Census Bureau. It defines a disability as a “long-lasting physical, mental, or emotional condition,” which “can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or

remembering,” and “can also impede a person from being able to go outside the home alone or to work at a job or business.” The key word in this complex definition is “can” – a condition *can* make activities difficult or *can* impede certain activities; many times they do not.

Disability rates in our region are fairly comparable to those in California and the nation. By coincidence, the table below is exclusive to Traditionalists (the total count was roughly 216,000 in PSA 4). Thus in 2000, approximately 90,000 people 65 and older had some type of disability in our region. Senior citizens with sensory or physical disabilities (32,000 and 62,000, respectively) may need some assistance from others to perform daily activities. Individuals with a mental disability (about 25,000 locally) may be able to complete routine tasks given proper guidance or supervision.

Types of Disabilities Among Persons 65+, 2000 Census	PSA 4	CA	US
Any Disability (Persons with 1 or more types of disabilities listed below)	41.7%	42.2%	41.9%
Sensory Disability (Blind, deaf, or a severe vision or hearing impairment)	14.8%	14.5%	14.2%
Physical Disability (A condition that substantially limits walking, climbing stairs, reaching, lifting, or carrying)	28.5%	28.4%	28.6%
Mental Disability (Difficulty learning, remembering or concentrating)	11.7%	12.2%	10.8%
Self-Care Disability (Difficulty dressing, bathing, or getting around inside the home)	9.2%	9.9%	9.5%
Difficulty Going Outside the Home Disability (Difficulty going outside the home alone to shop or visit a doctor’s office)	19.3%	20.8%	20.4%

By definition, older people with a “self-care” disability are reliant on others for meeting one or more of their personal needs; this describes just under 20,000 seniors in Area 4. The “Going Outside the Home” category is used to estimate the number of homebound seniors; 19.3% equates to nearly 42,000 older people in the region who must rely on others for transportation.¹

The latest research suggests that among all Americans 65 and older who are living in the community (as opposed to residing in nursing homes), 26% have difficulty with one or more activities of daily living (ADLs)^c, and an additional 12% have trouble with one or more instrumental activities of daily living (IADLs).³ Nationally, it appears that somewhere between 8% and 10% of all seniors have difficulties with daily tasks that are significant enough to require help from others; this is consistent with the aforementioned measure of a self-care disability.⁴

Projecting the Number of People with Functional Limitations

“We’re seeing some very powerful evidence all pointing to parallel findings. . . people are not as healthy as they approach retirement as they were in older generations. It’s very disturbing.”

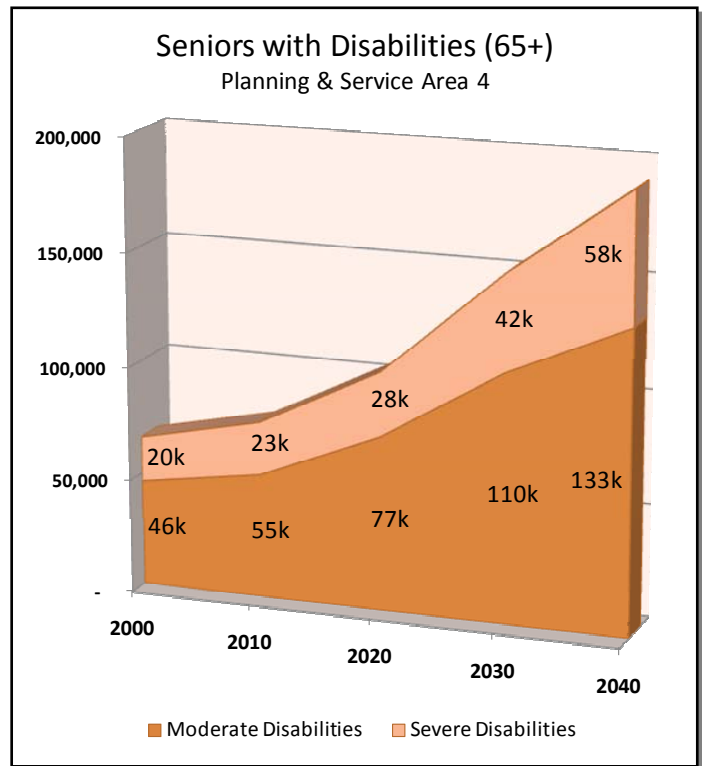
*Dr. Mark D. Hayward
Sociologist, University of Texas at Austin*

Because an older person’s functioning level largely determines whether he or she will need in-home or community-based assistance to remain independent, our single most critical question is: In the future, will older adults as a whole be more healthy or less healthy? The answer appears to be both more and less.

A new study from the Urban Institute’s Retirement Project, *Meeting the Long-Term Care Needs of the Baby Boomers*, uses sophisticated computer modeling methods to estimate how

many senior citizens will have “disabilities” through the year 2040. Their “intermediate scenario” predicts the overall disability rate for people 65 and older will decline until 2020, then begin to rise as the Baby Boomers approach their 80th birthdays. The researchers cite increasing rates of diabetes and obesity as the key reasons for the reversal.

Despite a temporary decline in the *proportion* of seniors with disabilities, the net effect nationally and in our area (as shown in the chart below) will be an overall increase in the *number* of older people with physical limitations that accelerates after 2020. In our region, the near tripling of the senior population from 2000 to 2040 will translate into a near tripling of the number of older persons with functional limitations over that time span.



*Moderate Disabilities = 1 or 2 ADL or IADLs
Severe Disabilities = 3 or more ADLs or IADLs*

Generational Differences and Disability Trends

New research based upon the Health and Retirement Study, the National Health Interview Survey, and others corroborates the claim that the Baby Boomers will be less healthy seniors than their parents were.

"The baby boomers were much less likely than their predecessors to describe their health as 'excellent' or 'very good,' and were more likely to report having difficulty with routine activities, such as walking several blocks or lifting 10 pounds. They were also more likely to report pain, drinking and psychiatric problems, and chronic problems such as high blood pressure, high cholesterol and diabetes."

Washington Post, 4/20/07

Some experts do not concede that the Boomer Generation is sicker than the Traditionalists. They suggest Boomers are better educated about health issues and more likely to complain about aches and pains than the prior generation who just accepted discomfort as a part of growing old. Semantic arguments aside, the end result seems clear: a higher proportion of Boomer seniors will seek treatment than do today.

On a different note, the adventuresome segment of the Boomer cohort is also sparking health news. The term "Boomeritis" has been coined by Dr. DiBubile, an orthopedic surgeon, who has seen more injuries among middle-aged athletes who are pushing their aging bodies further than they care to go.⁵ The American Hospital Association (2007) expects a 33% increase in sports injuries by 2030.

To better understand how future disability rates may change, it is helpful to consider how and why older people have health problems in the first place. The remainder of Part Two addresses this subject.

B. Disabilities and Limitations Associated with Normal Aging

Many gerontologists believe the maximum human lifespan is 122 years. As more and more external or "un-natural" threats to our longevity are reduced (e.g. childhood disease, exposure to toxins, violent crime), people are living longer and longer. And, everyone who lives long enough can expect to develop some physical limitations as a result of "natural" or biological decline.⁶ Chronological age is strongly associated with functional ability. While just 10% of people in the 65-74 range have some type of disability, 50% of those 85 and older have one or more disabilities. This is why the 85+ demographic uses health services at a higher rate than any other age group. Most seniors (69%) will develop at least one disability in their lifetime.⁷



At the age of 112, Sacramento County resident George Francis was America's oldest living man.

Vision problems are one of the most common, and most disruptive, types of "normal" ailments older people endure. The leading causes of vision impairment and blindness are age-related. After age 76, the incidences of glaucoma, diabetic blindness, cataracts and macular degeneration all rise rapidly. Vision loss can occur if these conditions are not treated.⁸ In 2005, there

were about 5,000 Traditionalists (then age 70+) who were legally blind in PSA 4.⁹

Normal aging presents challenges for mobility in general and for driving in particular. In section A we saw that some 40,000 local seniors are unable to drive. It is estimated that the typical older adult will now “outlive” their ability to safely drive a car by about 8 years.¹⁰ Vision loss and dementia are the principle contributors to this statistic. The loss of one’s driver’s license, at the very least, introduces periodic dependence upon friends, family members and/or transportation services as most people must travel a fair distance to get to the bank, grocery store, doctor’s office and other frequent destinations.

C. Disabilities and Limitations Associated with Health Problems

Older people also develop functional limitations for “un-natural” reasons. To complicate matters, elderly individuals often have multiple health problems at any given time and their symptoms influence each other. This makes diagnosis and treatment much more difficult in older patients, and it underscores the need for primary care physicians and other medical professionals to receive specialized training in geriatric care.⁶

Major Chronic Conditions

Chronic diseases are those that are seldom cured; they are long-lasting and increasingly common.¹¹ The most prevalent chronic conditions for older adults in our region are: hypertension, arthritis, cancer, heart disease and diabetes.¹² As with disabilities, advancing age is highly correlated with the presence of each of these health problems. In the 65+ demographic, “80 percent have at least one chronic disease that requires ongoing care and management.”¹¹

When severe, each of these chronic conditions can reduce a person’s quality of life, limit their ability to perform daily functions, and most can

1	Heart Disease
2	Cancer
3	Stroke
4	Chronic Lower Respiratory Diseases
5	Alzheimer’s Disease
6	Flu/Pneumonia
7	Diabetes
8	Unintentional Injury
9	Hypertension
10	Nephritis (Kidney disease)
<i>CDC, National Vital Statistics Report, 2005</i>	

ultimately result in death. Conditions that commonly result in an individual needing assistance from others for a prolonged period include stroke, diabetes and arthritis.

Due to advances in medicine and better control of risk factors, people are far more likely to survive a stroke, and the prognosis for recovery is better as well.¹³ Still, an older person who suffers a major stroke is likely to be partially paralyzed and may have speech, vision and balance difficulties. Consequently, they will require care for the duration of their lives, either at home or in a skilled nursing setting.

Diabetes may lead to fatigue, muscle weakness, loss of vision, kidney disease, foot disease, heart attack and stroke. Unfortunately, the incidence of this disease is on the rise for people of all ages. Today, about 16% of the Traditionalist senior citizens in our area (27,000 people) have either Type I or Type II diabetes. By the year 2030 when all the Boomers are over 65, one quarter of them (about 125,000 people) are projected to be living with this disease.¹¹ This alarming increase has major implications for health care providers, for all organizations that make meals for seniors, and for family caregivers who must learn to properly care for loved ones with diabetes, to name a few.

Arthritis refers to a large group of conditions involving inflammation of joints, rheumatoid and osteoarthritis being the most serious types. Not only does arthritis produce discomfort and pain, in about 37% of cases it can decrease one's manual dexterity and overall mobility.¹⁴ In 2001, over half (52.5%) of Americans 60 and older were diagnosed with some form of arthritis. By 2030, half of all Baby Boomers are also expected to have this condition.¹¹ This will push the total number of local, over 60 sufferers from 165,000 to roughly 435,000. Among other things, this trend will likely heighten demand for assistive devices and for modifications in homes and public buildings (e.g., replacing door knobs with levered handles).

Memory Problems

"Every 72 seconds someone in America develops Alzheimer's."

Alzheimer's Association, 2008

Sometimes, older people are in good physical shape, but they cannot function independently because of a cognitive or emotional problem. By far, the most profound issue in this category is Alzheimer's disease. It is estimated that 500,000 Californians have Alzheimer's today.¹⁵ This could equate to as many as 25,000 cases in our region (specific estimates are not available).

The apparent explosion of Alzheimer's has more to do with a combination of longevity (people now living long enough to develop it), advances in life-extending treatments, and early diagnosis than it does with an increase in the incidence of the disease.¹⁶ It is estimated that half of all people 85 and older have some form of dementia, the majority of which is caused by Alzheimer's. They are also living longer with the disease than before; up to 20 years.¹⁷ This should be a great concern to everyone, because according to the Census Bureau (2006), "more

than seven out of ten people with [Alzheimer's] disease live at home and 75 percent of them receive care from family caregivers."

More people (Boomers and Pre-Boomers) are now being diagnosed with the disease in their 50s and 60s. The Alzheimer's Association (2006) conservatively estimates that over 220,000 Americans (perhaps over 1,000 people locally) already have what's known as "early onset" Alzheimer's disease and other types of dementias.

Depression

Depression is also a pervasive problem among older adults. Severe depression is associated with more frequent physical illness, greater disability and higher use of health services. Nationally, 11% of men and 17% of women 65 and older suffer from depression.¹⁸ Although it is treatable in 80% of cases, most older people never receive a formal diagnosis and most go untreated or undertreated.¹⁹ In PSA 4, about 2,000 Traditionalists (1.9%) reported feeling downhearted all the time in 2001.²⁰ Our own recent research found that working family caregivers' top concern is that their loved ones are sad, lonely or depressed.²¹

Aging with Developmental Disabilities

A relatively new phenomenon is aging among people with developmental disabilities. In the past, persons with disabilities were seldom expected to outlive their non-disabled peers. Due to medical advances, this outlook has drastically changed. As of 2006, there were 33,386 developmentally disabled Baby Boomers in California.²² An issue that has not yet been addressed by service providers or policymakers is: Who will care for aged persons with developmental disabilities when their parents or caregivers become frail elders themselves?

D. Health Disparities & Other Risk Factors

In most instances, disease processes involve a complex interplay between genetic (hereditary), environmental, and behavioral factors. Each of these elements also cross with socio-economic factors, placing certain categories of individuals at greater or lesser risk. Eliminating health disparities is one of the primary objectives of the U.S. Department of Health and Human Services. Such disparities include:

- ◆ Elder women are more likely than men to be disabled.²³
- ◆ African Americans have the greatest chance of dying from chronic diseases while Asian Americans have the smallest chance.²⁴
- ◆ Regardless of sex or ethnicity, people with some post-secondary education have lower death rates than those without it.²⁴
- ◆ A person living in poverty is three times more likely to have a disability than those 300% above the federal poverty level.²⁵

While we cannot alter our family histories, or erase the effects of hazards we may have been exposed to as younger people (e.g., asbestos), it is never too late to adopt healthy habits. A good diet and regular exercise have been proven to reduce the risk of most any ailment.²⁶ For example, it is estimated that 80% of heart disease cases could have been avoided through healthy living. Conversely, a poor diet and lack of exercise are often a formula for obesity; it is a major risk factor for a number of chronic conditions, particularly diabetes.²⁴

Two-thirds of Americans are overweight today,²⁷ and California has experienced the fastest rates of increase in adult obesity of any state in the nation over the past 10 years.²⁸ Traditionalists in PSA 4 are similar to all California adults; approximately 29,000 of them (17.5%) are considered obese today, and another 60,000 (36.5%) are overweight.¹² Both that ratio and that number

will likely increase over time because the Baby Boomers, as a whole, are less physically active than prior generations.²⁷ One third of all Boomers are projected to be clinically obese by 2030.¹¹

Other Threats to Independence

Sometimes, the “cure” is worse than the condition. This is certainly the case with prescription drugs. Seventy-five percent of senior citizens take four or more medications every day, even though doing so places them at an elevated risk of medication misuse, drug interactions and falls.²⁹ The California Board of Pharmacy (2006) estimates that half of all seniors do not take their medications properly; in extreme cases, the results are fatal.

By far, the most common cause of accidental injury (and death) for people 65 and older is falls in the home. It is estimated that one-third of America’s seniors experience a fall every year.³⁰ In our region in 2005, this equated to about 80,850 older people. Roughly half of these fallers experienced minor injuries and about 18% (just under 15,000 seniors) were hurt badly enough to go to an emergency room where most were treated and sent home. Less than one-third of senior fallers (4,190) were admitted to local hospitals (often for a bone break or fracture), and about half of that number were discharged to a nursing home for prolonged care. In 2005, *at least* 96 older adults in our region died as a direct result of a fall; in contrast, 35 were killed in motor vehicle accidents – the second highest cause of injury deaths.³¹

Live Strong and Safe

Falls Prevention Program



A4AA's *Live Strong and Safe* program features home modification, medication management, nutrition, exercise and balance. For more details go to: www.a4aa.com



The tandem of population aging and greater longevity also elevates the number of economically needy senior citizens. More and more, people in our seven county region reach their 60th birthdays without sufficient financial resources,¹ and except for the wealthy few, unexpectedly long lifespans among the oldest old tend to erode their retirement nest eggs. Part Three of this report presents a new method for measuring economic need, illustrates average living expenses for local seniors, discusses various threats to one’s financial security and addresses transfers of wealth within families. As a whole, the Baby Boom generation is approaching retirement in worse financial shape than their Traditionalist parents did, and the number of “needy” seniors will likely more than triple by 2030.

A. The “Economically Needy” Senior Population, Today and Tomorrow

The older person’s basic desire to remain as independent as possible often conflicts with their economic realities. Whereas one’s health status dictates the need for assistance, one’s financial standing will largely determine the quantity and quality of care that an individual can obtain.

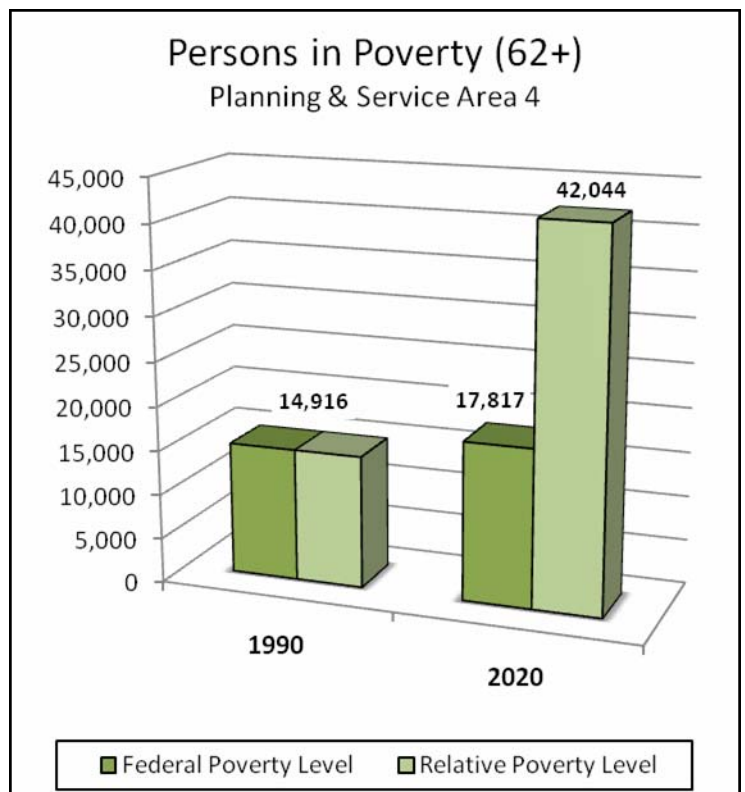
Projecting the Number of People with Economic Need

For 50 years the Federal Poverty Level (FPL) has been the standard measure used when determining economic need for individuals. Recently, experts have challenged the validity of the measure.^{2,3,4,5,6} The FPL is based on the consumer price index; it does not account for the costs of transportation, housing, or most importantly, the rising costs of health care. The measure also fails to consider changing life circumstances, family status, or regional variations in costs.³

Researchers at the Urban Institute have devised an alternative variable. Their Relative Poverty Level is indexed to wages and “shows how many people fall below an unchanging *percentage* of average real income, adjusted for family size, instead of an unchanging absolute real income level.”⁶ The Urban Institute has projected the federal and the relative poverty rates for the year 2020. The green

chart below presents an adaptation of their model for persons age 62 and older in our seven county service area.^d

The federal poverty rate for older adults is expected to fall (as it has fairly steadily since 1959) in the years ahead. Nevertheless, the increase in senior population in our area will result in a net increase of *persons* in poverty. In contrast, the Urban Institute’s Relative Poverty Rate will increase along with the population,



resulting in a dramatic 182% spike in the number of local seniors who will “feel” as though they are living in poverty in the year 2020.^e

Generational Differences and Economic Need

(O)nly a quarter of [Boomers] will be comfortably set in retirement; at the other extreme, a quarter will end their years in poverty. Half of all Baby Boomers fall somewhere in between. Unless they collect some form of employer-backed benefit, like a pension – many of them won’t – they’ll likely have to work part-time to make ends meet.”

John Gist

AARP Public Policy Institute, Associate Director

We have seen that by the year 2020, the estimated number of economically needy seniors in our region will exceed 40,000. Among them will be a growing number of Baby Boomers who, by then, will be between 56 and 74 years old; roughly half will have reached the traditional retirement age of 65.

Whereas the Traditionalists (many of whom lived through the Great Depression) are commonly described as thrifty savers, their Boomer children who were raised in a far more prosperous era are notorious spenders. How many Boomers will have saved enough to assure their financial security for what figures to be a very long retirement? That figures to be one of the single greatest questions on the minds of top policy makers.

Social and historical factors play a major role in the conversation about the economic health of these divergent generations. The Traditionalists, as a group, accumulated substantial wealth throughout their adult lives as a result of three key events:

- 1) the advent of tax-deductible company pensions in the 1940s which covered 10 million employees by the end of that decade;

- 2) the G.I. Bill which was used by 8 million WWII veterans to attend college or trade schools;
- 3) a 25-year-long real estate boom beginning in 1970 and fueled, ironically, by a shortage of homes available for young Baby Boomer newlyweds.⁷

Today, the pre-retiree Boomer is confronted by evaporating pensions, college debt (from their children’s higher education) and a nationwide housing market bust.

Continuing Financial Disparities

The poverty projections shown in the green chart are based on aggregate figures for particular age groups. As stated previously, not all members of a generation are alike. When it comes to financial standing, strong socio-economic tendencies persist.

- ◆ Men fare better than women;⁴
- ◆ Those born in the U.S. fare better than those born in another country;⁸
- ◆ Couples fare better than single people;⁴
- ◆ Highly educated people fare better than lesser educated people.²

Consequently, the group that generally struggles the most to make ends meet is ethnic females without a college degree who are living alone. According to author Harry R. Moody, “(a)n older person who is simultaneously a member of two (or more) disadvantaged groups, faces what has been called double jeopardy or multiple jeopardy.” For example, “for African American women with disabilities, the double jeopardy of minority and disability status becomes triple jeopardy with the added element of gender.”⁹

To better understand future financial need among older adults, we now turn our attention to some of the major economic challenges that are associated with aging. These include fundamental issues that all seniors face as well as external threats that can impact people of all ages.

B. Basic Financial Challenges

Associated with Aging

Except for those who have the good fortune to be relatively wealthy and the wisdom to invest properly, America’s seniors generally find that the longer they live, the less financially secure they become.

A Typical Senior’s Budget: The Elder Standard

“Knowing the true cost of living for older adults is vital if we are to ensure that elder Californians can meet basic needs and maintain their independence.”

*Steven P. Wallace,
UCLA School of Public Health*

In February 2008, the Insight Center for Community and Economic Development released findings from their California Elder Economic Security Initiative which used a new method to determine how much income older people need to meet their basic living costs. A condensed table for Sacramento County is shown below.

Examination of the Elder Economic Security Standard reveals that the amount of money needed

to meet one’s basic needs varies widely based upon the size of the household (single person vs. couple), the housing type (owner vs. renter), and housing costs (mortgage vs. no mortgage).^f The last of these, housing costs, are the single largest expense for everyone except those without a mortgage, and the housing item accounts for all of the cost variation within the “person” and the “couple” categories. Thus having affordable housing is really the key to economic security.

Insight utilizes the Elder Standard figures to demonstrate, in actual dollars, that older adults across the state fall well short of the average costs of living when their only source of income is either SSI or standard Social Security benefits. In fact, the data shows that the FPL covers less than half of the basic living costs for people 65 and older in California.^g Thus seniors must have additional sources of retirement income to make ends meet, according to this modest budget.^h

Women are disproportionately affected by financial challenges. In California, the median retirement income for a female is 82% of that for a male (\$22,588 versus \$27,361).

Sacramento County, Elder Economic Security Standard™ Index, 2007

Monthly Expenses	Elder Person		Elder Couple	
	Owner with Mortgage	Renter, 1 Bedroom	Owner, No Mortgage	Owner with Mortgage
Housing	\$1,333	\$813	\$412	\$1,333
Food	263	263	486	486
Transportation	202	202	323	323
Health Care (Good Health)	283	283	566	566
Miscellaneous @ 20%	232	232	357	357
Monthly Elder Standard	\$2,313	\$1,793	\$2,144	\$3,064
Annual Elder Standard	\$27,752	\$21,517	\$25,723	\$36,773

(Adapted from Insight: California Elder Economic Security Initiative, 2007)

Over Time, Buying Power Declines and Costs of Living Rise

The Senior Citizens League (2008) recently found that people 65 and older have lost 51% of their buying power since the year 2000. The study reviewed typical senior expenses such as food, housing, MediCal, Medicare Part B, gasoline prices, and recreation between 2000 and 2008. While seniors receive a cost-of-living adjustment (COLA) each year in their Social Security checks, it has not kept pace with inflation. According to the League, “(s)ince 2000, the Social Security COLA has increased average benefits just 24 percent while typical senior expenses have risen by 88 percent, almost four times as fast.”

An Older Person’s Income Remains Static or Falls Over Time

When it comes to financial stability among seniors, there is no greater issue than Social Security. The solvency of the program will be addressed in Part Five. Future concerns aside, federal statistics show that 40% of seniors would immediately fall below into poverty if they stopped receiving their Social Security check.¹⁰ “A majority of the 48 million Americans aged 65 and over who receive a Social Security check depend on it for at least 50 percent of their total income, and one in three beneficiaries rely on it for 90 percent or more of their total income.”¹¹

In the past, workers could rely upon a company pension for added retirement income. Today, 401k plans are rapidly replacing traditional, defined-benefit pension plans; just 37% of all working Americans were covered by a traditional plan as of 2005.¹² Overall, this means Baby Boomers will need to contribute far more to their retirement plans than their parents did if they hope to glean the same benefit. Even those who have traditional plans must be wary. As United Airlines’ recent \$9 billion pension default made clear, there is no guarantee that those

defined benefits will be fully preserved if the parent company falls upon hard times.¹³

The Retirement Question

In our region in 2005, 8.9% of Traditionalists (then age 70+), 36.6% of Pre-Boomers (then age 60-69) and 75.2% of Baby Boomers (including those then age 45-59) were in the labor force.¹

Many people believe most of the Boomer Generation will work past age 65. However, early reports in 2008 show a significant number of the eldest Boomers are actually opting for early retirement at age 62. According to the Social Security Administration’s press officer, “about half of the people take what we would call ‘early retirement.’ That trend has held for many years now.”¹⁴

The question of how Boomers retire may be equally as important as when. Certainly, there will be a portion who will continue to work because they must; they are likely to hold relatively low-paying jobs with few (or no) benefits, particularly health insurance. A larger group may be those interested in “downshifting” into a retirement that includes more relaxed and more interesting work experiences; ironically, some of them may also be forfeiting health coverage (not to mention high salaries and status) in order to pursue new ventures.¹⁵ The Employee Benefit Research Institute estimates that a “low-risk” couple retiring today at age 65 should have \$635,000 in savings to cover the medical expenses they will incur during the remainder of their lifetimes.¹⁶

Volatility on Wall Street has also affected people’s post-employment plans. A new AARP survey found that among people 50 and older who had lost money in the stock market during the past 12 months, 28% said they had postponed retirement.¹⁷ A study by AIG SunAmerica indicates that Baby Boomers have grown increasingly leery of the stock market. Most

Boomers polled (80%) said that having a “significant source of retirement income guaranteed for life” is a major goal.¹⁸

Of course a person’s decision to retire is not theirs alone to make. One-third of retirees felt their departure from the workforce was “forced.”¹⁹ A 2004 AARP survey also found that two-thirds of workers age 45+ feel age discrimination hinders professional advancement and well-being.²⁰

It is estimated that half of all workers are involuntarily pushed into retirement as a result of health problems, financial obligations or market conditions. Research at Boston College found that many companies were “lukewarm” about making special accommodations for older workers.²¹ For older people needing to get back into the workforce, research has shown that it takes them considerably longer to find a job (24 weeks versus 18 weeks, on average).²²

C. Unexpected Threats to One’s Economic Status

During late adulthood, individuals and families often encounter various “catastrophic shocks” that can have permanent, negative impacts on their financial standing.²³ We have already touched upon widowhood and underemployment; other “threats” can include unexpected family care, health emergencies and elder abuse.

Family Care

Long before the typical middle-aged person must confront the full realities of their own aging, they often become involved in the care of frail parents and/or parents-in-law. Based on national patterns, we estimate that some 115,000 Baby Boomers in PSA 4 are currently occupying this role.²⁴ New research suggests that, on average, these family caregivers spend \$5,500 a year of their own money to help loved ones make ends meet.²⁵ This added cost, not to mention the

other limitations of the aging services network, comes as an unwelcome surprise to most Boomers. Often times, they mistakenly believe that Medicare pays for all long term care costs for an unlimited amount of time.²⁶

Health Emergency

Virtually every American faces the risk of financial ruin due to a severe health problem that requires extensive, specialized care. Medical costs continue to rise, and medical bills are cited as the number one reason families are forced to declare bankruptcy.²⁷ Those who have the highest risk of economic loss, of course, are the uninsured. In 2005, roughly 46,000 Baby Boomers (8.5%) in Area 4 had no health insurance. For Pre-Boomers who were age 60 up to age 64, the percentage of uninsured was higher (11.1%).²⁸ Apparently, this is true because a higher proportion of people in their early 60s are out of the workforce, and those unable to pay for a private health plan simply go without.

Elder Abuse

Sadly, older people who are fortunate enough to avoid all of the aforementioned pitfalls may still have their economic security jeopardized by crafty criminals or unscrupulous family members. According to the California Attorney General’s office, nearly 200,000 older Californians are victims of abuse every year – most of it financial. Identity theft, just one form of financial abuse, is one of the fastest growing crimes in America.²⁹

D. Assets and Transfers of Wealth

“It’s possible that most Boomers will inherit not a windfall, but simply the wind.”

John Gist, AARP Public Policy Institute

In an ideal situation, a person enters retirement with a solid financial foundation which will support their economic needs for the remainder of their lives. Some of our eldest citizens now

realize that they underestimated how long they would live, how long their funds would last, or both. From start to finish, it seems clear that Boomers' post-employment financial paths will be very different than their parents' have been.³⁰ Therefore, it is even more crucial that when making retirement plans, they account for changing conditions over the long-term (such as life-extending medical advances and global economic swings, in particular). Those who fail to do so will risk repeating the fate of elders who outlived their assets.

The Housing Market Meltdown

Most young seniors will not have the luxury of drawing from a large retirement fund. For the typical person, their greatest asset is their home. The shocking condition of the local housing market has been well documented. In October 2008, the median price for a home in Sacramento County was \$195,000. Homes have literally lost half their value in three years, plummeting 49.6% since the last high point in August of 2005.³¹



According to the California Senior Legal Hotline, senior citizens "have been the chief targets of predatory lending and mortgage rescue scams designed to steal the equity that has accumulated in their properties over decades." The Hotline handled nearly 300 foreclosure-related cases involving seniors in 2008.³²

In the short term, the housing market bust impacts all homeowners who want or need home equity dollars to cover expenses. In the long term, the more troubling question becomes: Who will buy all the Baby Boomers' houses when they ultimately do retire? Experts worry Boomer sellers will far outnumber prospective home buyers, thereby driving down property values.³³

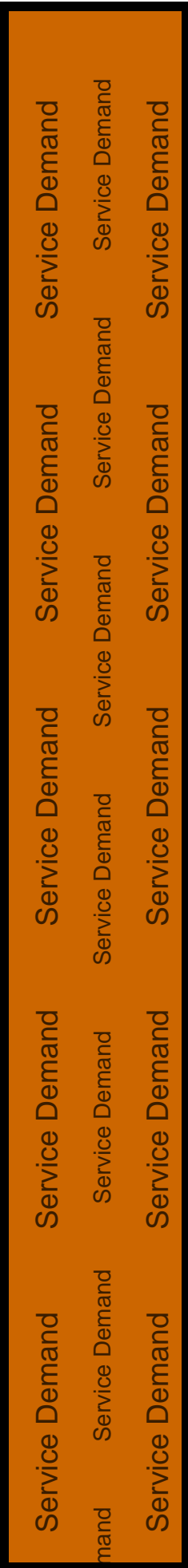
As stated previously, a longer lifespan for today's senior population generally equates to higher care costs. Increasingly, elderly people find themselves forced to liquidate assets to cover these expenses. The reverse mortgage is a relatively new product designed to allow the older homeowner to do just this.¹ While spending the equity in one's home is sometimes a good solution for Traditionalists, it does not bode well for Boomer children who may be banking on inheriting the family home as part of their own retirement strategy.

Some "ifs" in the Family Inheritance

In recent years, some observers have thought that when their parents pass away, the Baby Boom generation will collectively inherit trillions of dollars. Today, most analysts agree these claims are grossly overstated.^{30,34,35} Even before the current economic crisis, Traditionalists have seen the value of their assets steadily decline for all the reasons outlined in this chapter. Experts believe 80% of Boomers will receive no significant inheritance whatsoever. For those who do, most can expect less than \$40,000 according to a recent poll.³⁵

For those families who do have a significant estate to pass on, Boomers still face some obstacles. They are likely to have siblings who must share the remaining assets, for one. There is also research to suggest that the "bequeath ethic" is waning, and older people with means are becoming more likely to treat themselves with trips and material goods than in the past.³⁰





Part Four: Estimating Overall Need and Service Demand

(E)ven under the most optimistic scenario, long-term care burdens on families and institutions will increase substantially in coming decades.

The Retirement Project
Johnson, Toohey and Wiener, 2007

The Dual Challenge: Service Demand

An estimated 66,000 local Traditionalists (30%) received assistance from others for daily tasks in the year 2000. Of these, about 8,000 were cared for in skilled nursing facilities. Remarkably, 30 years later (when they are 95+), almost as many nursing home beds may be occupied by the surviving members of this oldest generation because 75% of them may need skilled care at that time.

By 2030, about one-quarter of the 66 to 84 year-old Baby Boomers (or 112,000 people) will also need some type of regular care, most of it likely being unpaid help from family and friends.

Thus far, estimates have been given for current persons with disabilities and current persons with economic needs. Part Four of this report presents a conceptual tool that combines the two. It measures how many people in a community are at risk of becoming dependent on others. We also adapt an Urban Institute model to forecast the use of skilled nursing and in-home care services through 2040. In short, the tripling of our local senior population guarantees *at least* a three-fold increase in service demand. At the present time, disturbingly few area seniors appear to be free of health and financial worries. Social and cultural changes may mean that in the future, an even smaller percentage of older adults will be relatively safe from concerns about their long-term independence.

A. Measuring Dependency in Older Adults

A great deal of information has been presented thus far, yet the basic question still remains: How many older people need assistance today, and how many more will need assistance tomorrow?

The Asset-Ability Matrix

At the most basic level, individuals who seek home and/or community-based care services generally have a physical limitation, an economic limitation, or both. To illustrate the subtle complexity of this concept, we have developed the Assets-Ability Matrix (see chart below).

The Matrix is a risk measurement tool. It is used to identify the relative risk of dependency that is caused by the combination of physical impair-

ment and economic need. Dependency in this context means a reliance on others for basic care needs. Such needs could range from needing help grocery shopping to needing help feeding oneself, for example. A person who does not rely on others at all is independent (has no dependency). A person who is completely reliant on others is totally dependent.

The Assets-Ability Matrix contains nine possible categories (squares) that a senior could fall into at a given point in time. Persons with low assets and low ability (the darkest red square) are most likely to be dependent on others for their care. Conversely, persons at the high asset and ability levels (the white square) are least likely to be dependent. Those who are in the center square have an uncertain degree of risk; an improvement in either their financial or physical status would move them to a low risk category (light pink squares), but a setback in either area would elevate them into a high risk situation (red squares).

Because advanced aging is associated with decreasing assets and declining physical abilities, the overall trend is for senior citizens to move toward the highest risk category (darkest red square) over time.

Using a combination of interrelated datasets from the Census Bureau's 2006 American Community Survey, we have computed estimated numbers of persons 65 and older in

		FINANCIAL ASSETS		
		LOW	MIDDLE	HIGH
PHYSICAL ABILITY	LOW	Highest Risk	High Risk	Moderate Risk
	MIDDLE	High Risk	Uncertain Risk	Low Risk
	HIGH	Moderate Risk	Low Risk	Lowest Risk

PSA 4 in each of the nine Matrix categories. As shown in the large chart, nearly 8,000 local citizens are in the highest risk group (darkest red). More than 30,000 additional seniors are in the high risk categories (red). Another 30,000

are classified as moderate risk (pink corner squares). Some 24,000 individuals have uncertain risk (center). Finally, less than one-third of all people age 65 and older in our region are in the lowest risk box (white).

Estimated Number of Seniors by Chances of Being Dependent, 2006

Planning & Service Area 4

Non-institutionalized population 65+ (N = 244,547 persons)

Source: Author's Calculations of American Community Survey data

Low Ability = "self-care disability"
 Middle Ability = "physical disability"
 High Ability = no disabilities

Assets based on household income:
 Low Assets = Less than \$20,000/yr
 Middle Assets = \$20,000 – \$45,000/yr
 High Assets = \$45,000 or more/yr

		FINANCIAL ASSETS		
		LOW	MIDDLE	HIGH
PHYSICAL ABILITY	LOW	Highest Risk 7,920 (3.2%)	High Risk 8,809 (3.6%)	Moderate Risk 10,739 (4.4%)
	MIDDLE	High Risk 21,633 (8.8%)	Uncertain Risk 24,225 (9.9%)	Low Risk 29,351 (12.0%)
	HIGH	Moderate Risk 19,296 (7.9%)	Low Risk 45,619 (18.7%)	Lowest Risk 76,955 (31.5%)

Estimating the Effects of Population Change

In the years ahead, the numbers of older people at risk of dependency will surely skyrocket as the overall population increases. But, will the *percentages* of people in the highest risk categories change? The broad trends that have been discussed previously seem to suggest that they will change, for the worse. For the Traditionalists, increasing longevity has a dual effect; it raises the likelihood that our eldest citizens will need some type of care in their final years and raises the odds that they will outlive their assets. Each of these outcomes will continue to directly impact their children, nearly all of whom are Baby Boomers, for at least two more decades.

In the meantime, as the Boomers themselves now begin to transition into senior citizenship, they appear to be arriving with more chronic health problems and less retirement security than their parents had at the same age. In fact, researchers at Duke (2004) who have analyzed past and present Census data found "boomers have the highest wage inequality of any recent generation." As of 2000, 10% of Baby Boomers were already living in poverty. As they approach their 70s and 80s, and health and financial strains accumulate, many may find it a short journey to the highest risk categories on the Assets-Ability Matrix.

B. Connecting Dependency with Service Use

“Frailty is a vitally important issue in the treatment of the elderly. . . . Frailty can strongly affect how an elderly person will respond to medical treatment, as well as how long and how well they will live. . . . [Yet] it remains poorly understood. . . . (F)railty is not a disease but rather a sort of intermediate state — between being functional and non-functional, and between being healthy and being sick.”

*Dr. John E. Morley
Gerontologist, St. Louis University Medical School*

Being at risk for dependency and actually *being* dependent (actively relying on others for assistance) are two different things. Just because an older person has trouble with a daily activity, that does not necessarily mean they get (or even want) help from someone else. And, just because a person is low-income, that does not mean it would be impossible for them to access fee-for-service care options. This makes it challenging to forecast how many individuals may seek out home and community-based services in the future. To do so, we must have some way to measure how many people are actually experiencing significant levels of dependency. The idea of frailty provides a way.

Like the term disability, “frailty” is somewhat troublesome because interpretations vary. In common use, it is associated with “aged” people and suggests a lack of strength and susceptibility to disease.¹ Often, it is used interchangeably with “85 and older,” even though not everyone in that demographic is frail, and much younger people are sometimes frail. Nevertheless, when interpreted from a clinical standpoint which assesses certain physical factors, the term is a powerful indicator of several things, including a general decline in health, falls in the home, deteriorating mobility, hospitalization and death. Frailty has also been found to be highly

correlated with cardiovascular disease, low education and poverty.²

C. Forecasting the Demand for Home and Institutional Care

In Part Two, we presented disability projections based upon the 2007 Urban Institute study. The primary purpose of that study was to demonstrate how the need for senior services will change in the decades ahead. In addition to disability status, older Americans’ future financial resources, the availability of family caregivers and other factors were used to estimate the demand for paid and unpaid long-term care in 2040. Again, we have adapted their findings to fit our local service area.

The graph to the right illustrates that the number of “frail” individuals receiving care services in our area will increase substantially through the year 2040. Each category of care spikes between 2020 and 2030 due to the “arrival” of the Baby Boomers. Although the rate of nursing home utilization (purple line) is expected to remain fairly constant (at around 12.5%), there will be a near tripling of the number of older persons in local skilled nursing facilities (SNFs) over that period because the number of frail persons will nearly triple during the first four decades of the century.

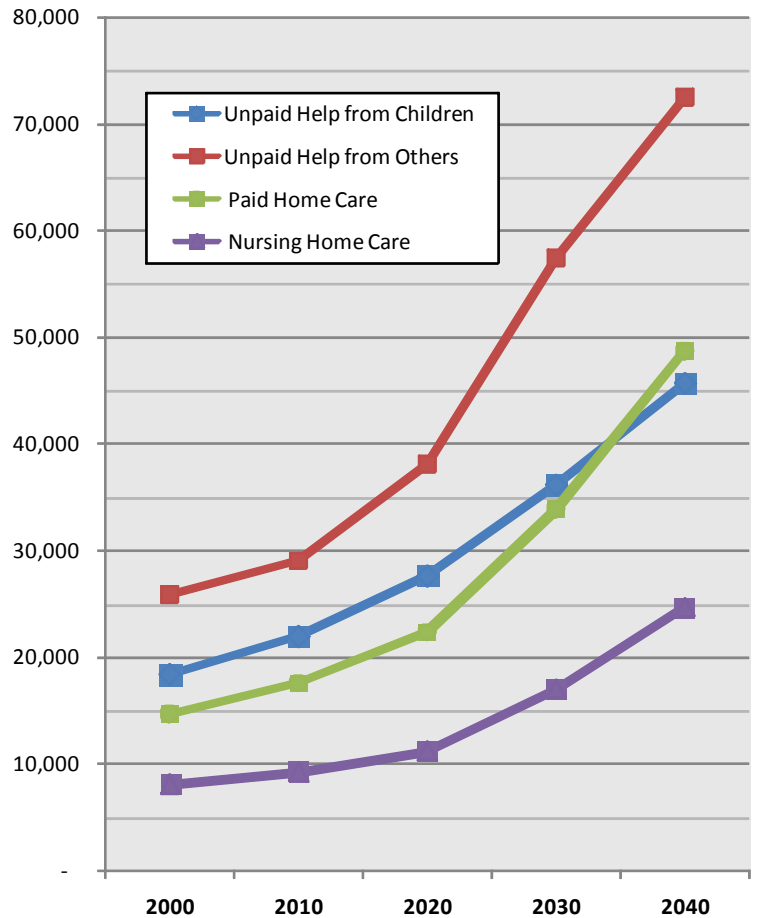
The percent of elders receiving paid care (green line) is rising while the percent receiving unpaid help from their adult children (blue line) is falling. According to researchers at the Urban Institute, a larger proportion of professional women will find it more economical to pay others to care for their elderly parents than to give up work to do so themselves. By 2040, more frail individuals will be getting care from a paid source than from their own sons and daughters. Finally, the proportion of frail individuals receiving help from “others” (red line), which includes spouses, other relatives,

neighbors, etc., is expected to drop slightly because the younger population will have smaller families.^k Nevertheless, population growth alone will account for close to a three-fold increase.

We suggest that the demand for community-based services (not shown) would most closely parallel (and may even surpass) the trajectory for paid care. Families who have begun using paid services have already implicitly expressed both a need and a willingness to accept help from “outsiders.” A variety of community-based programs nicely augment home services, and an option like adult day care can partially offset the need for private home care. Family caregivers may be able to find supportive services for themselves in community settings as well.

It must be noted that these projections assume an adequate supply of nursing home beds and home care workers will be available. This is a sizeable assumption; many experts predict there will be a severe shortage of people willing to work in the long term care field in the years ahead.^{3,4,5} It is also highly presumptuous to believe that community-based services will be readily accessible. Part 5 outlines a number of reasons why that would be the case.

Frail Individuals Receiving Care Services
Planning & Service Area 4





Part Five:

Limitations of the Aging Services Network

We have a fragmented network of services that is beyond its capacity. We face an unprecedented growth in the aging population, yet we continue to face critical budget crises at the state and national levels that threaten the core of services essential to keeping the senior population in their homes and communities.

Patty Berg
California Assemblywoman

The Dual Challenge: Service Limitations

The eldest Traditionalists qualified for both “old age” programs, Medicare and the Older Americans Act, when they were established in 1965. At that time, life expectancy was 70 years of age. Four decades later, many members of that generation are still with us, having not yet reached their early 80s — the new life expectancy benchmark. If this long standing pattern continues, the average Baby Boomer will live to be 100.

The unprecedented challenge we face is that the aging services network has not been updated, and it is now unsustainable in its present form.

In the 1960s, publicly funded home and community-based services (HCBS) were originally designed to *support* the needs of elders, not to *solve* their care challenges. Since then, a steadily increasing number of seniors coping with a state of semi-dependency, the introduction of cost-containing measures in acute health care, and inconsistent fiscal support for public services have all placed great stress on the system. As a result, today the aging services network is poorly equipped to respond to the dual challenge of sustaining vital programs for the oldest old while simultaneously engineering new ones for the coming Baby Boomers. Part Five of this report describes these trends, identifies care options that are available for our older citizens and addresses the unprecedented challenge which lies ahead.

A. A Brief History of Aging Services

For the purposes of this report, home and community-based services (HCBS) are defined as non-medical services that are provided in a person's private residence or at a public facility (such as a senior center) and that are intended to help the individual maintain independence and avoid placement in a care home. Examples of HCBS for older adults include adult day care, case management, home-delivered meals, information and assistance, in-home care, minor home modification, transportation and visitation programs. These services facilitate "aging in place" by delivering necessary supports to the elder person where they live.

The Evolution of Home and Community-Based Services

The evolution of the complex array of publicly funded home and community-based services that exists today began with the passage of the Older Americans Act (OAA) in 1965 (the same year that Medicare was established). The federal government recognized that the growing "elderly" population of 60-year-olds would need assistance to live independently – assistance in the form of central information hubs, legal help, meals on wheels, and many other programs. In passing the Act, they also approved the development of an infrastructure to deliver these services.¹

As early as 1977, the State of California was publicly criticized for its inability to establish an efficient, coordinated system of services for older adults, and those criticisms have persisted.¹ Today, there are over a dozen state agencies offering more than 125 different programs to older Californians, each with varying regulations and eligibility restrictions.² Nevertheless, hundreds of thousands of seniors and their caregivers benefit from one or more of these federal and state programs each year.

"Advances" of Modern Medicine: Longer Life, more Dependency

"Advances in medical diagnostics, pharmaceuticals, surgical techniques, and nutrition have eliminated many of the problems that once caused people to die prematurely The irony of our successes is that we have produced legions of long-lived elders who struggle with exactly those chronic health problems – heart disease, cancer, arthritis, osteoporosis, Alzheimer's – that our system is ill-prepared to handle."

Ken Dychtwald, Age Wave

Ken Dychtwald is among those who are critical of the medical community for not addressing the consequences of its success. He points out "(o)ne century ago, the average adult spent only 1 percent of his or her life in a morbid or ill state; today's average adult will spend more than 10

percent of his or her life sick” (Age Wave, p.112). More troubling still is the glaring absence of geriatrics training. In California, there is 1 geriatrician for every 4,000 people 65 and older.³ In contrast, there is 1 pediatrician for every 1,219 children in the state.⁴

Devolution of the Health Care System: Cascading Levels of Care

There has been a gradual erosion in the quantity and type of care that primary health providers offer. In the 1960’s, the phrase “long term care” would have conjured images of people in state-run institutions. In those days, when a person was sick they stayed in the hospital until they were well enough to be sent home (in 1968 the average stay for people 65+ was 14 days). Today, “long term care,” as it is commonly used, refers to the kind of care people need but that the hospital (and the health system in general) no longer provides. It has become unusual for an older person to have a hospital stay longer than five days, even for a major injury or serious illness. Thereafter, a very sick person may be discharged to a skilled nursing or rehabilitation facility; most patients are sent directly home from the hospital.⁵

The most critical gap in the health care system from our perspective is that “custodial care” is not considered health care unless it is provided by a medical professional. Custodial care is defined by Medicare as “nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom.” This means that neither in-home assistance with daily activities nor assisted living are traditionally covered by Medicare, by Medicare Supplemental (Medi-Gap) plans, by employer-paid retiree plans, or by Medicare Advantage (HMO) plans.^m People can purchase long term care insurance, however, to obtain some coverage for future costs.



Older adults are expected to receive custodial care from family members, particularly a spouse or adult children. Those without willing or able family caregivers have two options: pay privately for in-home help, or apply for limited assistance through a county (In-Home Supportive Services (IHSS)) or nonprofit program. According to the Congressional Budget Office, the total cost of long term care (including in-home, assisted, and skilled nursing care) in the year 2000 was \$120 billion; 59% was financed through government sources, 1% was financed by private insurance companies, and 40% of the cost was paid by individuals and families.⁶ The inability of many seniors to obtain an appropriate amount and an adequate quality of care has created a great divide in the care continuum.

Political Advocacy and Aging Services

The local supply of HCBS for older Americans is directly and indirectly anchored to all levels of government and thus to the larger political process. Historically, elected officials in Washington D.C. have expressed public support for senior programs but have not always been able to deliver the funds to sustain them. The prospect of greatly *expanding* services for older people has rarely been tangible given that federal budget deficits have badly outnumbered surpluses since 1965.

This leads to the question of political influence. Has it made a difference? The American Association of Retired Persons (AARP) was formed in 1958. Today AARP is by far the largest and most powerful lobbying force for senior issues in Congress. Their support was critical to the passage of the 2003 Medicare Modernization Act (which created the controversial Medicare Part D prescription drug program) – the most significant change to old age benefits in recent memory. Currently, the organization is pushing for reform of the Social Security system. At the state and local level, senior advocacy groups include Gray Panthers, Older Women’s League (OWL), League of Women Voters and the Congress of California Seniors.

B. The State of Home and Community-Based Care Today

Unfortunately, little progress has been made toward improving the aging services network in recent years, and in many areas, circumstances have deteriorated. On the national scale, there are serious concerns about the solvency of Social Security and Medicare. In individual households, family caregivers face even heavier demands. And at the community level, vital services are besieged by budget shortfalls.

Big Questions Loom about Basic Old Age Benefits

“Unless the government makes fundamental changes . . . the coming surge of spending on Social Security and Medicare will bring a fiscal tsunami of spending and debt that threatens to swamp our ship of state, damaging the U.S. economy.”

*David M. Walker,
former U.S. Comptroller General*

The overall demand for assistance is largely driven by older adults’ financial standing and by their ability to access health care. Thus larger

governmental decisions around Social Security benefits, Medicare and Medi-Cal have an indirect but profound effect on how many seniors will turn to in-home and community-based services in our local area.



In 2007, U.S. Senators Pete Domenici (R-NM) and Dianne Feinstein (D-CA) introduced the Social Security and Medicare Solvency Commission Act which created a permanent commission to make recommendations on maintaining long-term financial stability for these entitlement programs.

The precarious state of Social Security has been well documented. Beginning in 2017, a critical mass of retired Baby Boomers will cause benefit payments to exceed revenues for the first time in the program’s history. This turning point will set the program on a course toward complete depletion of resources, which is currently projected to happen by 2041.⁷

Medicare also faces an unsustainable future if it remains in its present form, but here the crisis will come much sooner. This year (2008), benefits granted will exceed revenues received, condemning this historic program to expend its last dollar by 2019. In the meantime, Medicare spending is expected to double as more and more elder Americans require acute care.⁸

Family Care: An Unstable Foundation

More and more, middle-aged people are finding themselves caring for frail elderly parents or other relatives. Most of these family caregivers are also working outside the home. In fact, a recent AARP study estimates that 18% of the total adult population in California is engaged in caregiving and that 70% of those adults are employed. Working caregivers often have difficulties when personal and professional responsibilities conflict. As the demands on the caregiver increase, adverse consequences tend to be compounded. In particular, difficulties at work, worries about one's own well-being, and poor mental health are all associated with having heavy caregiving responsibilities.⁹

Over time, family caregiving will likely last longer (because of increasing longevity), will be more intensive (because of decreasing health among the elderly), and will be more consuming (because of fewer supportive services). Affected caregivers may have markedly less time and energy for paid work and for personal interests. To make matters worse, there will be fewer family caregivers available for the challenge (as noted in Part One of this report).



Safety-Net Services

On September 23rd Governor Schwarzenegger signed the 2008-09 budget, bringing California's longest fiscal stalemate to an end. As the state took action to close a \$15.2 billion gap between revenues and expenditures, safety-net programs for seniors were adversely affected as follows:

- ◆ A 10% cut in Medi-Cal reimbursement rates for providers was extended through 2/09.
- ◆ Funding for county Medi-Cal administration was cut by \$42.2 million.
- ◆ Cost of living increases for SSI/SSP recipients were suspended.
- ◆ Funding for county operation of Food Stamp and IHSS programs (in-home care for frail seniors and people with disabilities) was cut by \$35.9 million (a 5% cut to IHSS).
- ◆ Department of Aging programs were cut by \$13.2 million (24%), including a \$3.8 million cut and the virtual elimination of state funding for the Long-term Care Ombudsman program (advocates for nursing home patients and assisted living residents), a \$2.5 million cut to the Multipurpose Senior Services Program (case management for frail, low-income elders), and a \$400,000 cut to Alzheimer's Day Care Resource Centers.
- ◆ Adult Protective Services (APS) Program (investigating allegations of elder abuse and neglect) cut by \$11.4 million (10%).
- ◆ Elimination of the Senior Citizens' Property and Renters' Tax Assistance programs (a cut of \$190.9 million).¹⁰

In response, the California Association of Area Agencies on Aging (C4A) released this statement:

"The Governor needs to work with the state Legislature on ways to maintain services to seniors — not acting to reduce funding and simultaneously hurting older people and jeopardizing an already fragile network of aging services throughout California."

Clay Kempf, C4A President, 10/3/08

Further state budget cuts could cause some Adult Day Health Care programs around the state to close their doors. These programs rely on Medi-Cal reimbursement for low-income participants; an additional 5% reduction is scheduled to take effect in March 2009.¹⁰ Potentially hundreds of our most frail citizens may need to be admitted to nursing homes if these programs cannot continue to operate.¹¹

Other Public Programs

The Older Americans Act programs have always been free to anyone 60 or older. Recently, the Administration on Aging has suggested that clients who can pay for a portion of their services should be encouraged to do so. Similarly, certain national initiatives appear to have greater focus on personal responsibility, particularly in the area of financial planning. These shifts seem to reflect concern over the “silver tsunami,” and a recognition that in the short-term, there is little choice but to try to do more with less.

In our region, the following programs exceeded their capacities long ago and currently have waiting lists: Alzheimer’s day care, care management (Linkages), home-delivered meals, in-home care services, respite for family caregivers, and transportation to and from local senior centers. The first two programs listed are supported by state funds and are subject to reductions this year. **As for the remaining services that have wait lists, if federal funding levels do not increase significantly, by 2030 the number of seniors and caregivers waiting to be served will likely exceed the number actually being served.**

Fee-For-Service Options

When no combination of help from family members, friends and neighbors is adequate, many older adults turn to private home care agencies for assistance with daily activities. This can be a good solution for those who can afford



to purchase the amount of care they need. If an individual requires more than 10 hours of care a day, placement in some type of residential care setting often becomes more economical and may be more appropriate as well.

In our region, there are a variety of large corporate agencies and smaller family owned businesses to choose from. The average cost of private home care (through an agency) in our area ranges from \$17.50 to \$25/hour, often with a four hour minimum. This expense is almost always out-of-pocket unless an individual purchased an applicable long term care insurance policy years in advance. Some families choose to directly hire an individual to work as an in-home caregiver. Generally, the hourly rate is lower and terms can be negotiated, but the worker may not be screened and bonded and there are tax implications to consider.

Social adult day programs are another type of fee-for-service option. They are generally sought out by family caregivers on behalf of an older person who could benefit from supervision and social stimulation for several hours during the day. These programs usually accommodate a small group of participants and they are few in number. Costs locally range from \$46 to \$75 per day, depending on the level of care. According to the National Adult Day Services Association, the average daily fee for adult day care is \$56.¹²

C. Understanding the Dual Challenge

“The aging network is gradually facing the contradiction inherent in attempting to have universal access to programs and at the same time to target services to those most in need. . . . Barring any infusion of new money, it is much more likely that distinct categories of boomers will be served because they happen to fit into existing or slightly redesigned services.”

*Patricia Maloney Alt
Future Directions for Public Senior Services*

In a weakened condition, the aging network now faces a profound challenge unlike any other. It must adapt to a new client base (the Baby Boomers) that is radically different from the existing one, and the network must move quickly. Very little attention is paid to the Pre-Boomers, yet watching them may provide our best glimpse of what will follow. Culturally similar to Boomers, today (2008) Pre-Boomers range from 63 to 72 years of age, and they have already begun accessing senior services.

The senior lunch program (congregate meals) is one of the original Older Americans Act services

designed in the 1960s. It provides a good example of an outdated service model. For decades, thousands of older people have made their way to neighborhood senior centers and other venues for a free, cafeteria-style meal. Recently, the supply of 60-somethings has dwindled. Why? Today’s young seniors are part of the Pre-Boomer generation, and the prospect of dining with fifty other people in an auditorium simply doesn’t appeal to them.

Whereas their parents (some of whom belong to the “silent” generation) have been comparatively passive clients of aging programs, the Baby Boomers (the so-called “me” generation) may be aggressive ones, demanding what they want, when they want it.^{3,13,14,15}

How do we revamp programs and services for tomorrow’s elders without compromising vital services for those with the greatest needs today? That is the dual challenge. Because of these stark generational differences, we anticipate a two-tiered system may evolve as both generations concurrently place increasing demands on the service network.



The aging network has come to a proverbial fork in the road. The question is not: Which path do we take? The question is: How do we take both paths at the same time?



The term “demographic preparedness” is meant to be analogous to disaster preparedness. Our service system is unsustainable in its present form. Unless we make changes, the aging of the community may become a destructive force. Like steadily rising floodwater, the collective needs of our most frail citizens will spill over the banks and flow unchecked into the wider community. If we fail to take necessary measures to protect people and systems, and if an aging “tsunami” is set in motion, it will not be over in days or weeks, it will last for decades. Demographic preparedness, then, refers to a state of readiness for both imminent and future challenges associated with rapid population growth, and it is applicable to individuals, organizations and governments. Part Six of this report offers broad recommendations and highlights some creative, local solutions.

A. Local Leadership

“We need leaders to come forth – people who can see and articulate the big picture and a framework to guide all the millions of little things that need to be done in every community, in every organization, and at every level of government.”

*Institute for the Future
Fault Lines in the Shifting Landscape*

There is little point in producing an exhaustive list of recommendations if no one intends to implement them. Who will step forward and answer the call for preparedness? If you are taking the time to read this report, we hope the answer is you. Whether you’re the CEO of a Fortune 500 company or simply an interested citizen, there are steps you can take that will make a difference in your life and in your community. Our region needs existing leaders to bring their skills and experience to the aging arena, and new leaders need to emerge.

Leadership in aging takes many forms. One does not need to literally lead a march on the capitol to be deemed an effective community leader (not that we discourage you from trying). It is important to begin by simply speaking out about the challenges that confront older adults and their caregivers, because these are truly community issues not just private ones. Anyone can lead by example – being a spokesperson

when opportunities arise within their own families, within their workplaces, within their churches, synagogues and mosques, and within their social and community circles.

Individual efforts tend to naturally evolve into more collective ones. By definition, a grass-roots movement must happen this way; it cannot be forced or fabricated. It is about people coming to a realization, one by one, that there is an issue that requires them to act, and it is about individuals first making a commitment within themselves to do so.

Throughout this recommendations section we have highlighted “**Local Leaders**” who are doing some remarkable things to move our community closer to a state of readiness for the future. They are proving that real progress can be made right here in the Sacramento area.

B. Recommendations

We do not presume to have all the answers. What we do have are general suggestions for steps that will begin to address the needs of our oldest citizens today and tomorrow. We carry forward the analogy of natural disasters because it points to familiar roles each group might play in responding to the potential social disaster that could result from the rapid aging of the population.

On the following pages, recommendations are offered for the following stakeholders:

- ◆ Individuals and Families
- ◆ Educators
- ◆ Local Governments
- ◆ Primary Health Care Providers
- ◆ Community-Based Organizations
- ◆ Faith-Based Organizations
- ◆ The Private Sector

C. Public-Private Partnerships

When multiple parties come together and work in collaboration, exciting results can be achieved. A public-private partnership (PPP) is “a government service or private business venture which is funded and operated through a partnership of government and one or more private sector companies. . . . A typical PPP example would be a hospital building financed and constructed by a private developer and then leased to the hospital authority.”¹

An intriguing example can be found in Milwaukee, Wisconsin. There, the resident association at a subsidized senior housing development wanted to assure they would

receive the services they needed. Ultimately, they worked with the city to create what became a public-private partnership between the housing authority, the county agency on aging, a major health care organization and a local ministry group. This project (the Lapham Park Venture) has been recognized for outstanding achievement by the National Academy of Public Administration.²

Is it realistic to think that something like this could be done in our area? One of the more inventive uses of a public-private partnership in the entire nation is the California Fuel Cell Partnership, located in West Sacramento. Car and oil companies, state government, mass transit agencies, PG&E and UC Davis are among the partners in this successful project which produces hydrogen powered vehicles.³

This reaffirms a central theme in this recommendations chapter. People living and working in the Sacramento region have the ingenuity to achieve remarkable things! We simply need to build upon early successes and attract more creative community leaders to the cause.



America's response to Hurricane Katrina in 2005 provides a sober frame of reference for understanding how the country might react to the so-called "Silver Tsunami" caused by the rapid aging of the population.

Individuals and Families

"As informed as we've all become about the factors that influence health, too many people continue to take too little responsibility for their own well-being. With maturity, the real challenge frequently shifts from *knowing* what to do, to *doing* what you know."

Ken Dychtwald
Age Wave

In the event of a natural disaster such as a flood, the best way to ensure safety is to be prepared. In the same way, personal preparation is the best way to minimize the impact of potentially "catastrophic" age-related events. Just as people can protect their home and family with sandbags and surplus food, they can protect themselves from dependency in later life through a healthy lifestyle and prudent financial planning. While none of these steps guarantee safety, each greatly improves the chances of a positive outcome.

Our aging preparedness suggestions for individuals and families are:

1) Adopt and maintain a healthy lifestyle.

Research on exercise and strength training in later life found that the oldest participants (85 and up) benefited the most from beginning a routine.⁴ It is never too late to be physically fit.

2) Revise your retirement plans with longevity in mind.

Many of our oldest citizens have lived much longer than they expected, and some have "outlived" their resources as a result. Today, it is estimated that most Baby Boomers will live to age 85.⁵ Twenty years from now life expectancy will surely be much higher. Every Boomer should plan to be 100.

3) Put together a long term care plan for yourself.

Far too many frail older adults are forced to impoverish themselves to qualify for Medi-Cal in order to pay for the long term care they need. To avoid this outcome, people must understand the serious limitations of Medicare and other health insurance in paying for "non-medical" care and plan accordingly. If current trends continue, an even larger share of costs will be transferred to patients.

4) Encourage your family members to do all of the above.

The families that do best in difficult elder care situations are the ones who are open and honest with one another. There are several resources on how to start a family conversation about these topics. The Family Caregiver Alliance has a helpful fact sheet on their website (www.caregiver.org).

LOCAL LEADERS in Innovative Housing

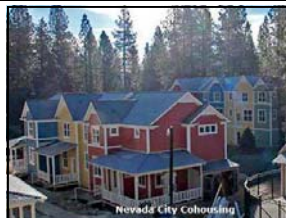
McCamant & Durrett Architects

Nevada City, CA

Project: Wolf Creek Lodge (Grass Valley)

Status: Opening in 2009

www.wolfcreekcommons.net



The married duo of Kathryn McCamant and Charles Durrett are pioneers in the area of co-housing. They now live in their Nevada City project while developing the next.

The intent of senior co-housing is to provide an old-fashioned type of community for seniors in which the focus is on mutual support, respect, and assistance. Residents have private rooms but also share common areas. For older people who don't have the support of neighbors or family members and don't care for the institutional-type provisions, the co-housing option can be ideal.



The Education System

“There is little public awareness, let alone understanding, of the changing aging process and its implications for the 21st century. . . . [A] public education initiative should focus on health, successful aging, and the changing meaning of growing older, profiling the new older Californians.”

*Institute for the Future
Fault Lines in the Shifting Landscape*

Education plays several supporting roles in the context of natural disasters. School children now learn about Hurricane Katrina in the classroom, colleges train the civil engineers who inspect levies, and major research institutions devise better ways to predict and track weather systems. By focusing in these three areas (basic education, professional training and research & development) the education system as a whole can do a great deal to improve the community’s state of readiness for the aging boom.

Our aging preparedness suggestions for education are:

1) Integrate discussions of older people and age-related topics into K-12 classrooms.

Individual teachers could emphasize aging topics when giving examples, having guest speakers and suggesting volunteer assignments. Formal integration of aging as a teaching subject would require action by school boards. The University of Texas has developed a K-12 curriculum that is of interest.⁶

2) Place greater emphasis on the study of aging issues in higher education.

College faculty generally have a good deal of latitude in what they are allowed to teach. They can encourage students at every level to explore aging issues, from Speech 101 to graduate dissertations.

3) Expand geriatric training for all health care professionals.

A large (and growing) portion of health care consumers are older people, yet those who serve them have little or no formal training on their unique issues and needs.⁷ College presidents could support an infusion of geriatric training for students in nursing, social work, EMT and public health programs.

LOCAL LEADERS in Education

UC Davis Center for Healthy Aging

Davis, CA

Project: Professional & Public Education



Few health professionals, let alone social service providers, have received much formal education on the natural aging process. UC Davis is addressing this critical need.



The Center for Healthy Aging offers many unique education programs: a UCTV healthy aging series, a successful aging series, training of the trainer, and more. The Mini Medical School creates a classroom environment of a medical school; diplomas are awarded at the end of the program. These programs promote education on aging issues, disease prevention & health.

Local Governments

“Preparing for the age explosion doesn’t just mean adding a few senior centers. Local governments will need to revisit all planning processes, especially general and capital improvement plans. . . . Progressive leaders will need to look both internally and externally for ways to finance innovative programs and services.”

*Center for Civic Partnerships
A Healthy Community Perspective on Aging Well, 2006*

When a major storm strikes, local government (emergency services) is the first to respond. When numerous victims are involved, a triage system is used to determine who can be helped and who cannot and to decide who needs immediate attention and who can wait. The findings in this report make it clear that rapid population aging will produce casualties, literally and figuratively. Unless they’re well prepared in advance, cities and counties will be forced to triage large numbers of seniors who need public assistance.

Our aging preparedness suggestions for local governments are:

1) Protect vulnerable elders from abuse.

Financial abuse by family members or others can quickly plunge an older person into a permanent state of economic dependency, and this is on the rise. Prosecuting offenders should be a top priority.

2) Preserve vital services for seniors.

When frail elders are forced to qualify for Medi-Cal to pay for skilled nursing care, this impacts the state budget which indirectly impacts county and city budgets. Thus it is in everyone’s best economic interests to support home and community-based services that prevent or postpone the placement of elderly people in nursing facilities.

3) Invest in preventative health care programs.

The leading causes of death in older people are chronic diseases. The costly consequences of heart disease, cancer and stroke can all be reduced through adult education and programming that encourages a healthy lifestyle. The City of Sacramento’s 50+ Wellness Program is one such program.

4) Encourage all government departments to prepare for an aging community.

Several years ago the Governor of New York directed 36 state agencies to analyze the impact of the aging population on their operations, to identify action steps and to implement changes.⁸ This initiative, known as Project 2015, provides an exemplary example of governmental preparedness.

LOCAL LEADERS in City Planning

City of Citrus Heights

Project: Neighborhood
Walkability Study

Status: Ongoing

Contact: mpoole@citrusheights.net



Local governments can promote wellness and reduce the likelihood of falls among older residents at the same time by improving and expanding public walkways.

The Neighborhood Walkability Survey arose from a grant from the California Healthy Cities and Communities Program. Over 500 surveys were returned and many neighborhood walks, talks, and photographs took place. Outcomes include short and longer term accessibility improvements (such as curb ramps and sidewalk infill projects), as well as a second year of funding that will help promote safe and accessible routes to destinations in addition to healthy and accessible activities.

Primary Health Care Providers

"Most doctors treat disease, and figure the rest will take care of itself. And if it doesn't – if a patient is becoming infirm and heading toward a nursing home – well, that isn't really a medical problem, is it?"

*Dr. Atul Gawande
Brigham And Women's Hospital*

In the immediate aftermath of a disaster, nearby hospitals and clinics are often overrun with victims in need of care. During the days that follow, secondary health problems often arise (e.g., when a flood causes contamination of drinking water), and there are typically difficulties reaching people in more remote areas. In the context of population aging, one can envision a similar scenario. Emergency rooms could be filled with seniors who have fallen and broken a wrist or bumped their head. Doctors' offices may be inundated with elderly flu patients who did not have access to vaccines. Access to acute care may simply be non-existent for older people in rural areas.

Our aging preparedness suggestions for health care providers are:

1) Expand services.

The American Hospital Association projects that emergency room visits, hospital admissions and routine doctor visits will all increase significantly due to the number of Boomers and the more complex nature of the chronic conditions they will have.⁹ Also, more resources will be needed in facilities and in home settings.

2) Place more emphasis on prevention and self-care.

Certain health outcomes can be anticipated (and treated) in advance if full assessments are completed (e.g., the Mini Mental State Exam for dementia). Primary care physicians need to have the time to do more complete diagnoses with older patients. With guidance, patients themselves can do more to document their symptoms, so health professionals will know how best to treat them.

3) Invest in new technologies that improve access to care.

For decades, computer technology has improved medical techniques; more recently it is improving communication between doctors and patients. Some health providers now offer online medical records and e-mail access to physicians. A more complex application is *telehealth* — the remote monitoring of patients' vital signs via transmission of data through telephone lines or the internet.

LOCAL LEADERS in Medical Technology

UC Davis Medical Center

Sacramento, CA

Project: Telemedicine Program

Status: Ongoing

www.ucdmc.ucdavis.edu



In the future, technologies like those being applied by UC Davis may enable frail people to continue living in their homes longer by greatly reducing the need for on-site supervision.

In the 1990s, the UC Davis Medical Center began what has become an award-winning telemedicine program. Using a video camera and a television monitor, medical specialists at UC Davis are able to see and communicate in real time with doctors at over 80 outlying locations throughout rural Northern California and Nevada. This technology is now being used to provide emergency room consultations; and in some cases, this avoids risky and costly air transport to Sacramento.

Community-Based Organizations

“(T)here is an opportunity to help boomers create a social legacy of profound importance. Their added years of life give them the chance. Their experiences in life give them the capability. And the need to come to terms with the world in a way that brings integrity to their life gives them the psychological incentive. . . . All of society will have a stake in the outcome.”

*Harvard School of Public Health – MetLife Foundation
Reinventing Aging: Baby Boomers and Civic Engagement, 2004*

More often than not, it is community-based organizations (CBOs) that take on the brunt of the relief effort in the wake of a disaster, tending to the needs of those who have been displaced from their homes. They are generally able to respond more quickly and operate with more flexibility than government agencies, and they maximize their impact through the use of dedicated volunteers. Already, an insufficient supply of home and community-based services puts elders at risk of “displacement.” In the years ahead, the assistance of CBOs will be needed to fill the void. If enough semi-retired and newly-retired Boomers can be swayed to join the ranks of volunteers, then collectively, these local groups may be up to the challenge.

Our aging preparedness suggestions for community organizations are:

1) Continue to provide vital services for older adults and family caregivers.

Within the broad community-based organizations category there are small, local groups dedicated to serving the needs of seniors (e.g., Citizens Who Care), and there are large, national organizations that often play a supporting role (e.g., Easter Seals). It is crucial these kinds of care options continue.

2) Advocate for the needs of your elder members.

Like all of us, CBOs are “aging in place.” Members of organizations that represent specific segments of the population are the logical spokespersons for the needs of their peers as they age. The gay community provides an example of a group whose interest in aging issues seems to be increasing.

3) Capitalize on an increasing base of prospective volunteers.

Thus far, the Baby Boomers have been less civic-minded than their parents were a generation ago, which raises concerns about the future of groups that rely on unpaid help. Community organizations will likely be in competition with one another as they “court” prospective volunteers.¹⁰

LOCAL LEADERS in Service Development

Asian Community Center

Sacramento, CA
Projects: Transit, Day Care, Housing
Status: Ongoing
www.accsv.org/



The key to long-term success is growth. Community organizations that can not only sustain themselves but expand their operations over time will lead the way.



Since 1972, the Asian Community Center (ACC) has been successfully developing and providing culturally sensitive programs for older adults. In recent years, they have established volunteer-based transportation and social day care programs. In 2007, ACC acquired nearby Greenhaven Terrace, a 166 unit apartment complex for active adults age 62 and older.

Faith-Based Organizations

“(M)ost religious organizations give priority to the young In the future, religious institutions will be increasingly serving two broad populations of the elderly. They are the old who require assistance in their lives and the old who seek new personal growth opportunities. . . . The next generation of religious leaders will have to expand their grasp of the religious journeys of the elderly, and arrange for services for the older congregant. . . . Long-term church membership can provide the basis for introducing a wide range of activities designed to raise the quality of life for elderly people who live alone.”

*James E. Birren
UCLA Center for Aging*

Natural disasters are often very distressing to those who are touched by them, directly or indirectly. People seem to seek comfort from faith-based organizations in such times. Similarly, as an increasing number of families find themselves dealing with disease, disability and death among their eldest members, religious communities will be called upon for support and guidance.

Our aging preparedness suggestions for faith-based organizations are:

1) Help your eldest members to continue living in their own homes.

There are many things that can help maintain the independence of frail elders. Using a phone tree to regularly check on homebound individuals is helpful. Having a system for offering rides to religious gatherings and other important events is very helpful. Developing programming specific to the needs and interests of older members is ideal (Fremont Presbyterian Church in Sacramento is an example).

2) Support your members who are involved in family caregiving.

Family members with heavy caregiving responsibilities experience tremendous stress. Faith-based groups can offer much-needed reassurance and emotional support for these individuals.

3) Help your members with end-of-life decision-making.

Religious groups also have a natural tie-in when older adults and their families are dealing with advance directives for health care, hospice care, making final arrangements and bereavement counseling, particularly for elderly widows and widowers. Groups that do not provide direct assistance in these areas can help their members by linking them with appropriate organizations that do.

LOCAL LEADERS in Community Service

Catholic Charities

Sacramento, CA

Project: Downtown Senior Outreach

Status: Ongoing

www.catholiccharitiesca.org



Faith-based groups seem to have a unique ability to reach older people who have the greatest needs — those with neither economic means nor emotional support from family or friends.

The Downtown Senior Outreach Program serves vulnerable seniors who live in single room occupancy hotels in downtown Sacramento. The program provides case management services and promotes successful independent living. Regular trips to the Food Bank and bingo games at the Cathedral Neighborhood Center have been effective ways to build a level of trust.



The Private Sector

“(T)he caregiving phenomenon is an employer issue – not just an employee issue. . . . Clearly, in terms of productivity and the bottom-line, businesses are seeing that there’s a legitimate financial advantage to be gained by attending to the needs of working caregivers.”

*Ron Moore
FamilyCare America*

In the aftermath of a natural disaster, commerce in the affected area is disrupted. Businesses strive to get up and running as quickly as possible, people return to work, and this aids in the recovery of the local economy. In a basic sense, the “Age Wave” figures to have a similar effect. The private sector will need to adjust to an altered environment (an aging consumer base, for one), and it will have to replace retiring Boomers with either younger or older workers.

Our aging preparedness suggestions for local businesses are:

1) Educate tomorrow’s retirees.

Large and small employers can play an important role in helping workers make an informed decision about when they will retire and how they will prepare for it. Baby Boomers taking early retirement this year (at age 62) have a good chance of living another 30 years.⁵ Can they really afford it?

2) Support working family caregivers.

According to *The MetLife Caregiving Cost Study*, employers in the United States lose an average of \$2,110 in productivity a year for every full-time employee who is a caregiver. This is primarily due to workday interruptions and time missed. Employers can make a difference by simply making resource information available. Advance planning tools that help employees understand their particular care options early on will usually save them a great deal of time, stress and frustration later.

3) Hire older workers.

Not only will more employees be “aging in place” as prudent Boomers and Pre-Boomers *postpone* full retirement, but an increasing number of older people will need to return to the workplace for additional income. More businesses are beginning to recognize and appreciate the perspective, the courtesy and the reliability that senior employees tend to offer.

LOCAL LEADERS in Employment

Kelly Services, Sacramento

Corporate Office: Troy, MI

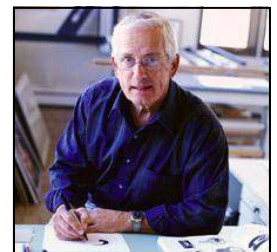
www.kellyservices.com



In the future, more and more older people will need to remain in the workforce. Employers will also need to adjust to having older employees.

Kelly Services has worked with A4AA’s Senior Employment Program to place more than 20 older people in jobs at McGraw-Hill to score standardized tests.

“Recruiting older workers is a win-win situation from every angle. As an employer, you will be able to bring employees to your workforce who have years of skills and experience. They will bring a unique perspective to your organization, which will have an impact on your current and future labor force.” — Kelly Services website





Conclusion

The older adult population in our seven county region will nearly triple between 2000 and 2040. Social and generational factors strongly suggest that the *proportion* of tomorrow's seniors who have health and financial needs will also rise. Neither families, nor health care providers, nor governments are prepared. Though these interrelated issues are highly complex, our conclusion is simple: We must act.

In 2007, the National Association of Area Agencies on Aging (n4a), Partners for Livable Communities, and the MetLife Foundation worked together to produce *A Blueprint for Action: Developing a Livable Community for All Ages*. This valuable resource suggests six steps to help counties and cities prepare for an aging population. They are:

- ◆ Step One: Assemble a Team of Public and Private Leaders
- ◆ Step Two: Assess the Community's Aging-Readiness
- ◆ Step Three: Take Focused Action
- ◆ Step Four: Promote Success
- ◆ Step Five: Set a Long-Term Course
- ◆ Step Six: Get Resources

It is our hope that this report, *The Dual Challenge*, will act as both a foundation and a catalyst for further efforts in our local area. Area 4 Agency on Aging is one of just a few organizations in the region that is actively working toward a collaborative approach to preparedness. We are looking for committed individuals and groups to join with us.

As a first step, we have included the "**Pledge to Prepare**" insert in this report. On it, you can express your willingness to get involved in a number of different ways, including: 1) participating in Area 4's ongoing efforts to plan for the Aging Boom and raise awareness about the issues presented in this report; 2) writing to your elected officials or local business and religious leaders; 3) joining a commission, council or committee; 4) volunteering with a project or local service provider; or 5) donating funds to support programs and services for seniors. We encourage you to send in your "Pledge" and to share it with others.

"Paradoxical as it may seem,
to believe in youth is to look backward;
to look forward we must believe in age."

Dorothy Sayers





PLEDGE to PREPARE *for the Aging Boom*

Your Name and Title: _____

Organization Name (if applicable): _____

Phone Number: _____ E-mail: _____

Please check all the items that apply to you or to your organization.

- I would like to be involved in Area 4's ongoing efforts to plan and to raise awareness about the Aging Boom.
- I would like to write letters supporting the improvement and expansion of senior programs and send them to local leaders.
- I would like to join a commission, council or committee that is working on improving or expanding senior programs in my area.
- I would like to volunteer my time to support a project or program that helps seniors or family caregivers in my area.
- I would like to make a donation to a project or program that is helping seniors or family caregivers in my area.
- Other (please specify): _____

In signing this document, I acknowledge the importance of preserving vital services for frail elders while also preparing for those who will become elderly in the future, and I pledge to be part of the solution!

Signature: _____

Please return to:

Area 4 Agency on Aging
2260 Park Towne Circle, Suite 100
Sacramento, CA 95825

Fax: (916) 486-9454 Website: www.a4aa.com





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Notes

Introduction

^a A cohort is a group of people who grew up during the same time period.

Executive Summary

^b Unless otherwise noted, the figures presented in this report are specific to the seven county region known as Planning and Service Area 4 (PSA 4), which includes Nevada, Placer, Sacramento, Sierra, Sutter, Yolo and Yuba Counties.

Part Two

^c The federal Administration on Aging defines ADLs as “activities usually performed for oneself in the course of a normal day.” Distinctions are often made between basic ADLs which are self-managing tasks (i.e., eating, bathing, dressing, toileting, transferring and walking) and instrumental activities of daily living (IADLs) which are skill-oriented tasks (e.g., light housework, preparing meals, taking medications, shopping for groceries or clothes, using the telephone and managing money).

Part Three

^d Age 62 is used because the model centers around the Social Security Administration’s benefit formula.

^e The projections presented here assume the Social Security system will continue to exist in its present form (including the stepped increase in the full benefit age). A significant revision of the system by the federal government would greatly alter this scenario.

^f Census data shows that the “typical” senior household consists of a married couple with a mortgage.

^g The federal poverty level for California in 2007 was \$10,400 for a single person, \$14,000 for a couple.

^h It must be noted that this estimated budget is based on a person in “good health.” According to the U.S. Bureau of Labor Statistics, Americans 65 and older spent an average of \$349 per month on health care (including prescription drugs and vitamins) in 2005. Also, data from the Consumer Expenditure Survey demonstrates that people 85+

and women pay, on average, close to 50% more for health care each year than their senior peers.

ⁱ Data was not available for Yuba and Sierra Counties; therefore, the labor force figures shown exclude those counties. Also due to a lack of data, Baby Boomers between the ages of 41 through 44 were excluded.

^j A4AA neither condemns nor endorses reverse mortgage products.

Part Four

^k Paid care, unpaid care from children, and unpaid care from others are not mutually exclusive categories. Many older adults receive assistance from all three sources.

Part Five

^l Area 4 Agency on Aging was among the first group of AAAs in the state; it opened in 1973. Over the years, various pilot projects were made into permanent, state-funded programs, including MSSP (case management for low-income people) and Adult Day Health Care (ADHC) in the 1970s, Linkages (care management for non low-income people) and Alzheimer’s Day Care Resource Centers (ADCRCs) in the 1980s, and In-Home Supportive Services (IHSS) in the 1990s.

^m Other states offer waivers which allow Medicaid dollars to pay for assisted living; California does not (although a small pilot project is now underway).

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