Strengths and Needs Assessment of Older Adults in the Denver Metro Area

Prepared for the Denver Regional Council of Governments

DRCOG
Denver Regional Council Of Governments

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October 5, 2004

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Acknowledgements

Aspen Media & Market Research
Jan Marie Belle, Southwest Improvement Council
Jennie Berzinskas, Catholic Charities
Sue Bozinovski, Director, DRCOG Aging Services Division
Todd Coffey, Program Specialist, Colorado Department of Human Services
Daniels Fund
Linh Hoai Duong, Vietnamese Elderly Association of Colorado
Mary Ellen Farace, Gilpin County Department of Human Services
Estevan Flores, Latino/a Research and Policy Center
Tom Gillogly, Program Specialist, Colorado Division of Aging and Adult Services
HealthONE Alliance
Jeanette Hensley, Director, Colorado Division of Aging and Adult Services
Rebecca Herr, Colorado Commission for the Deaf and Hard of Hearing
The Jay and Rose Phillips Family Foundation
Grant Jones, Metro Denver Black Church Initiative
Phil Jones, Grants Manager, DRCOG Aging Services Division
Kristina Kaparich
Bonnie Kelly, Community Services Program Administrator, DRCOG Aging Services Division
Carmah Lawler, Older Lesbians Organizing for Change
Jeff May, Director, DRCOG Metro Vision Resource Center
Ray and Diane McGeorge, Colorado Center for the Blind
Gwen Million, Eaton Terrace II Assisted Living Center
Lynn Osterkamp
Our Lady of Guadalupe Church
Arlene Peterson, Senior Hub
Sorya Pollack, Vietnamese Elderly Association of Colorado
Alan Press
Jeff Romaine, Program Manager, DRCOG Metro Vision Resource Center
Rose Community Foundation
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The Colorado Trust
The Jay and Rose Phillips Family Foundation
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About The Denver Regional Council of Governments (DRCOG)

DRCOG is an association of 51 local governments committed to protecting and enhancing the quality of life in the Denver metropolitan area and is the planning agency for the region. The Aging Services Division within DRCOG is formally designated by the Colorado Department of Human Services as the Area Agency on Aging (AAA) for the counties of Adams, Arapahoe, Clear Creek, Douglas, Gilpin and Jefferson, the City and County of Broomfield, and the City and County of Denver. In this capacity, the agency is responsible for developing four-year and annual plans for aging services for the region. These plans must be based on periodic assessments of the needs and strengths of adults aged 60 and over, as well as their caregivers.

DRCOG's Aging Services Division provides two direct service programs to older adults and their families and caregivers, including Information and Assistance and the Long-term Care Ombudsman Program. In addition to inquiry response, DRCOG produces The Senior Resource Directory, The Nursing Home Survey and the Caregiver Handbook. The Long-term Care Ombudsman Program provides free advocacy support to nursing home and assisted living facility residents in the Denver metro area. Assistance is provided not only to residents, but also friends and relatives of residents, facility staff and administrators. Ombudsmen serve as spokespersons for facility residents investigating complaints and reporting problems or concerns related to the care of residents.

In addition to these direct services, DRCOG awards approximately $6 million per year to dozens of community agencies that serve older adults and/or their caregivers. These agencies provide mandated services such as transportation, in-home care, legal assistance, and meals, among others. These services are described further throughout this report. The decision to allocate available funds to specific service categories is based in part, on periodic, strategically valid studies of the needs and strengths of seniors throughout the region.

DRCOG intends to use this strengths and needs assessment to set priorities for programs and services for older adults as plans are made to accommodate the growing population of older adults living in the eight Denver metro counties. This assessment was supported in part by the Daniels Fund, The Jay and Rose Phillips Family Foundation, HealthONE Alliance, Rose Community Foundation and The Colorado Trust.

About National Research Center, Inc. (NRC)

NRC is a leading survey research and evaluation firm based in Boulder, Colorado, focusing on the information needs of the public sector, including governments, non-profit agencies, health care providers and foundations. Its principals have worked more than 20 years in critical areas such as human service needs assessments and evaluations, client satisfaction, local government service delivery and more.

About the NRC Research Team

The NRC research team was led by Kerry Lupher, MSW, overall project manager, Shannon Hayden, BA, survey manager, and Erin Caldwell, MSPH, profiles and projections manager. In addition to its staff, the NRC team included partners Reid Reynolds, PhD, principal of Reynolds Analytics and past demographer for the State of Colorado; Steve Fisher, PhD, an independent financial and economic consultant; and Linda Piper, MA, gerontology instructor at University of Northern Colorado and former AAA director. A blue ribbon panel of specialists contributed its independent perspectives to augment the guidance received from DRCOG, Colorado Division of Aging and Adult Services and Boulder County Aging Services Division. Report authors are listed on the title page.

Executive Summary

Study Background, Purpose and Methodology

The purpose of this study was to conduct a high-quality assessment that included a statistically valid survey of the strengths and needs of older adults in the eight-county DRCOG AAA region, which includes the counties of Adams, Arapahoe, Clear Creek, Douglas, Gilpin and Jefferson and the City and County of Broomfield and the City and County of Denver. This report is intended to enable DRCOG, local governments and other policymakers to understand more accurately and predict the services and resources required to serve an increasingly aging metropolitan population. With this report, DRCOG stakeholders will shape public policy, educate the public and assist communities and organizations in their efforts to sustain a high quality of life for older adults.

The objectives of the Strengths and Needs Assessment of Older Adults were to:

- Identify the strengths and articulate the needs of older adults in the region.
- Develop estimates of and projections for the cost of meeting the needs.
- Provide useful, timely and important qualitative and quantitative information for planning, resources development and advocacy efforts.

NRC used several different data sources to create a picture of the strengths and needs of older adults in the DRCOG region. The NRC research team began the study by documenting the current and projecting the future demographic characteristics of the older adults in the eight counties using the 2000 Census and population projections made by DRCOG. Current utilization and costs came from the Social Asset Management System (SAMS) maintained by the State of Colorado and the Final Expenditure Reports based on the Aging Services Form 480 (AAS480).

A 20-minute survey of older adults was conducted by phone with a stratified random sample of residents of the eight-county DRCOG region. Interviews were conducted from April 14 to June 21, 2004. A total of 2,000 completed surveys were obtained, providing an overall response rate of 17%.

A 10-minute telephone survey was conducted with 200 Baby Boomers from a stratified random sample. Interviews were conducted from June 28 to July 5, 2004. The response rate was 24%.

To help capture the voices of difficult-to-reach older adults, NRC facilitated 11 focus groups with the following groups of older adults: African Americans; American Indians; Asian Americans; Latinos/as; gay, lesbian, bisexual or transgender (GLBT); blind or vision impaired; deaf or hearing impaired; residents of an assisted living center; grandparents raising their grandchildren; caregivers of their older adult family members and older adults living in a rural area. The focus groups lasted about an hour and a half each. Focus groups varied in size from 5 to 17 individuals, a facilitator and the scribe.

Included in this report are multiple terms used interchangeably to describe individuals in different racial and ethnic groups. The terms used vary according to the information source (e.g., U.S. Census, group identification) and include the following: Black or African American; Asian or Asian American; Hispanic, Latino or Latino/a. Often respondents are split into two groups, white or not white and Hispanic or not Hispanic.

Study Results

Demographic Profile and Projections of Older Adults

Size and Growth

- In the year 2000, there were 261,286 older adults (persons 60 and over) living in the eight-county DRCOG region.
- Older adults accounted for 12% of the region's total population, representing an increase of 49,184 or 19% from the older adult population in 1990. The younger population (under 60), swelled by an influx of migrants from elsewhere in the U.S. and abroad, grew more rapidly (25%). As a result, the Denver region has a somewhat lower concentration of older adults than the nation as a whole (12% vs. 16%).

Geographic Distribution within the DRCOG Region

- Denver County accounted for the largest proportion of older adults in the DRCOG region with 30% followed by Jefferson County (27%), Arapahoe County (22%) and Adams County (15%). The remaining four counties in the region accounted for 6% of the region's older adult population.

Urban/Rural

- The Census Bureau defines a rural area as, essentially, any territory that is not "urban." While most of the land area in the Denver Region is rural, the vast majority of the population (95%) lives in "urbanized areas," with a concentration of 1,000 or more persons per square mile, or "urban clusters," with a density of at least 500 persons per square mile.
- The Census classified 11,536, or 4%, of the DRCOG region's older adults as "rural" in 2000. The proportion of rural older adult residents ranged from near 100% in Gilpin and Clear Creek counties to none in Denver County.
- Using the Census definition of rural, the proportion of older adults living in rural areas declined with age, from 6.1% of those 60 to 64 years old to 2.6% of those 85 years old and over.

Age and Gender

- In assessing the strengths and needs of the older adult population it is helpful to understand that the majority of older adults falls in age groups that might be classified as the "young-old," where the ability to live independently is common, while a minority, most of whom are "old-old," are more likely to require some form of assistance to continue to live independently. For the purposes of this report, those age 60 to 74 were considered the young-old and those age 75 and over were the old-old. Using this distinction, the young-old comprised nearly two-thirds (66%) of the older adult population of the Denver region.
- Because women outlive men, older age groups have higher proportions of women. For all older adults in the Denver region, women outnumbered men by 57% to 43%. In the 60 to 64 age group women constituted a small majority of 52%; this majority grew to 71% for those age 85 and over.

Race and Origin

- In the year 2000, there were 21,380 Hispanic or Latino, 11,038 Black or African American, 5,372 Asian and 918 American Indian and Alaskan Native older adults. These nearly 40,000 minority older adults accounted for about 15% of the older adult population in the Denver region.
- The proportion of persons identifying themselves as Hispanic or Latino, African American only, Asian only or American Indian/Alaskan Native only was higher among persons aged 0-59 compared to those 60 and older.

Language Spoken at Home and Ability to Speak English

- The ability to speak and understand English can affect how easy or difficult it is for an older adult to access services. Thirteen percent or 25,620 of Denver's older adults reported speaking a language other than English at home.
- However, of these, about three-quarters felt that they spoke English either "very well" or "well." Only 6,321 indicated that they spoke English either "not well" or "not at all," representing 2.4% of all older adults.
- Of those older adults that who did not speak English well or at all, 41% spoke Spanish, 27% spoke another Indo-European language (e.g., Russian) and 29% spoke an Asian language.

Living Arrangements

- The ability to live independently in the community as older people age often depends on whether or not they live alone. Nearly two-thirds (64%) of Denver older adults lived in family households with either a spouse or some other relative.
- Many (57,117), however, lived alone and older women were about three times more likely to live alone than older men. Slightly more than half of older adults living alone were age 75 and older.
- In addition, about five percent of older adults lived in what the Census Bureau classifies as "group quarters," which, for older adults, are mostly nursing facilities.

Rent/Own Status (Tenure)

- Most Denver older adults (77.4%) lived in owner-occupied units. The proportion declined with age, dropping from over 80 percent for those 60 to 74, to 74.4% for those 75 to 84 and 56.5% for those age 85 and over.

Educational Attainment

- Nearly one quarter (23%) of Denver older adults held a bachelor's and/or a graduate or professional degree. A similar proportion (24%) attended college and may have earned an associate degree. An additional 30% were high school graduates; the remaining 23% did not graduate from high school.

Employment Status

- Many older adults continue to work for pay. At the time of the 2000 Census, 64,849 (24.8%) older adults in the Denver region were employed. However, the proportion employed dropped sharply with age. Roughly half of young older adults (those 60 to 64) were employed – 58.9% of men and 45.2% of women. In each age group a higher proportion of men than women were employed.

Household Income

- For all age groups, median household income increased with age until it peaked at over $65,000 for the 45 to 54 age group. It then dropped markedly for each subsequent age group – $56,746 for the 55 to 64 age group; $37,042 for the 65 to 74 age group and only $26,695 for the 75 and over age group.

Poverty Status

- Another indicator of economic wellbeing is the portion of older adults near or below the federally designated poverty level. For 1999 (the income year for the 2000 Census) the poverty threshold for a person 65 or over living alone was $7,990; for a two-person household with the householder 65 or over it was $10,075. (Poverty thresholds are adjusted annually to reflect changes in the cost of living. For 2003, the latest year for which thresholds have been set, the comparable figures were $8,825 and $11,122.)
- In 1999, the incomes of almost 13,000 (7%) older adults in the Denver region were below the federally designated poverty level. Poverty rates were substantially higher for older women than men and the levels and differentials increased with age. Slightly more than one in ten women 75 and over had incomes below the federal poverty level in 1999.
- Because of the low level of the official poverty level, information on older adults living below three multiples of the federal poverty level – 150%, 175% and 200% – has been included. For comparison, a person 65 or over living alone would exceed the 200% level with an annual income of $15,980 in 1999 ($20,150 for two people). (The thresholds for 2003 were: $17,650 and $22,244, respectively.)
- Fifteen percent of persons 65 and over had incomes below 150% of poverty and nearly one in four (24%) had incomes less than 200% of poverty. The proportions were higher for those 75 and over than for those 65 to 74.
- Using 200% of poverty as a broad measure of economic need, nearly 45,000 older adults were poor or "near poor" in 1999.
- Poverty rates were substantially higher for minority adults 65 and over. Whether using the official poverty level or some multiple of it, poverty was nearly twice as prevalent among Hispanic, Black and American Indian older adults than for all older adults in the Denver region. Poverty was also more prevalent among Asian older adults, but not to the extent found among the other minorities.

Disability Status

- The 2000 Census asked two questions that yielded useful information on the prevalence of selected disabilities among older adults. The first asked whether the respondent had a long-lasting condition such as blindness, deafness, a severe vision or hearing impairment or a condition that limits physical activities such as walking or climbing stairs. The second question asked whether the respondent had a "physical, mental or emotional condition lasting six months or more" that caused difficulty "learning, remembering or concentrating," "dressing, bathing or getting around inside the house," "going outside the home to shop or visit a doctor's office" or "working at a job or business." Responses to these questions determine whether a person is classified as having one or more "sensory," "physical," "mental" or "self-care" disabilities.

- The 2000 Census found that nearly 40% of older adults in the Denver region reported one or more of these disabilities. Slightly more than half of these reported two or more disabilities.
- Females were slightly more likely to report a disability than males (40% vs. 38%) and more likely to report two or more disabilities than men (22% vs. 17%).
- Minority older adults were more likely to indicate that they had one or more of the disabilities included in the Census. Roughly half of Hispanic (49%), Black (53%) and American Indian (46%) adults age 65 or older reported one or more disability. The proportion for Asian older adults was 37%.

Grandparents as Caregivers

- For the first time in the history of the Census, the 2000 Census asked about grandparents who lived with and cared for their grandchildren under the age of 18. In the Denver region there were 36,493 such grandparents and 14,243 (39%) were "currently responsible for most of the basic needs" of at least some of the grandchildren with whom they lived. Slightly more than half of these grandparents had been responsible for a grandchild for 3 or more years. (The data on grandparents include those of any age, not just grandparents 60 and over.)
- Minority grandparents were more likely to reside with their grandchildren; the proportion of grandparents living with their grandchildren ranged from 5% for Blacks to 9% for Hispanics; while the rate for the total population was only 3%.
- The proportion of grandparents responsible for the grandchildren that resided with them ranged from 22% for Asians to 53% for Blacks. Thus, Blacks in the Denver region were somewhat less likely to reside with their own grandchildren than other minority grandparents but those who did were more likely to have primary responsibility for their grandchildren.

Projected Growth of the Older Adult Population in the DRCOG Region

- According to projections prepared by the DRCOG, the number of adults age 60 or older is expected to almost double from an estimated 291,603 in 2004 to 575,175 in the year 2020. Further, as Baby Boomers age, the growth rate for older adults is expected to accelerate from a 2.8% annual rate from 2000 to 2004 to over 4% per year for the period 2004 to 2020.
- For the near future, these projections show higher rates of growth for the "young-old" (those under 75) than the "old-old." This is the period when the leading edge of the Baby Boom – those born in the late 1940s – reach their sixtieth birthday. (The peak of the Baby Boom – those born in the mid-1950s – will not reach their sixtieth birthday until after 2012.) The Baby Boom bulge in the Denver region will be especially pronounced because Denver has attracted large numbers of Baby Boomers who moved here from other regions as younger adults.
- With regard to the service needs of older adults, the trend in the immediate future is more benign than in the longer run. In the near future, the highest growth rates will be for the young-old that tend to need fewer services. After 2012, however, the 75 to 79 age group is expected to surge at an annual rate of 5.2%. Nevertheless, the anticipated annual growth rate for the population 85 and over will exceed 2% per year for the next eight years. This is the age group with the highest risk of institutional placement and where the need for services is likely to be greatest.
- The DRCOG projections also show expected growth in the older adult population at the county level. Between 2004 and 2020 the population 60 and over is expected to grow at an annual rate

of 4.3%. This will vary from a low of 2.3% in Denver County, which currently has the largest number of older adults, to 9.0% in Douglas County, which currently has a relatively small older adult population.

Strengths and Needs of Older Adults

The Challenges of Everyday Life for Older Adults

Problems Faced by Older Adults

- Just under half of survey respondents said that their physical health had been problematic in the previous 12-month period. About one-quarter of respondents mentioned affording necessary medications, financial difficulties and depression each as at least a "minor" problem and about one in five reported "major" or "minor" problems with feeling lonely, sad or isolated, performing everyday activities or having too few activities.
- Fewer respondents (less than 20%) cited each of the following categories as "major" or "minor" problems: getting necessary health care, providing care for another person, being financially exploited, dealing with legal issues, having inadequate transportation, having housing suited to their needs, having enough food to eat or being physically or emotionally abused.

Problems Compared by Year

- When compared to the 1999 survey results, respondents' problem ratings were similar for five items: financial problems, having too few activities or feeling bored, being financially exploited, providing care for another person and having enough food to eat.
- Nine problems were cited by a smaller proportion of respondents in 2004 than in 1999: being physically or emotionally abused; physical health; having inadequate transportation; getting necessary health care; having housing suited to needs; performing everyday activities such as walking, bathing or getting in and out of a chair; feeling depressed; feeling lonely, sad or isolated and dealing with legal issues.

Problems Compared by Respondent Characteristics

- Douglas County residents tended to report fewer problems than residents in the region overall, while Adams County residents generally reported a higher incidence of problems.
- Men age 60 to 74 tended to report fewer problems than women for some problems, including physical health and loneliness, and the oldest males (age 85 and over) reported fewer problems in general.
- For women, problems with physical health and everyday activities increased with age.
- Hispanic respondents had a higher incidence of most problems, as did respondents who were not white.
- Renters rated all but two of the potential problems as being more problematic for them than did homeowners.
- More problems were experienced by those living alone and those with less education.
- Having lower income or having a condition that was limiting physically yielded among the highest incidences of problems.

Caregiving

- Survey respondents were asked a series of questions regarding caregiving. Twenty-two percent of residents said that they provided care for one or more family members or friends on a regular basis, down from 29% in 1999.
- Of those who said they provided care, seven in ten (71%) were caregivers to a single person, 12% were providing care to two family members or friends and 17% identified three or more individuals for whom they were providing care. The average number of caregiving recipients was 1.6.
- Respondents were asked to whom they provided care. The most frequently mentioned unprompted category was a respondent's spouse, with 41% of caregivers saying that a spouse was someone for whom they provided care. Next most commonly mentioned were grandchildren (21% of respondents), other family members (18%) and parents (16%).
- When providing care for someone in the "other" category, grandchildren or a friend or neighbor, respondents reported the highest average number of recipients (4.2 "others," 1.9 grandchildren and 1.8 friends or neighbors).
- Older adults caring for adult children reported the highest average number of caregiving hours (19.8 hours per week), followed by those caring for "others" (17.4 hours).

Potential Problems Related to Caregiving

- According to the survey, 13% of caregivers "frequently" had felt burdened by caregiving in the last two months, one-quarter "sometimes" had felt burdened and 62% said they had "never" felt burdened in that period of time.
- Survey respondents who said that they were caregivers were asked about the frequency with which they had experienced each in a set of potential problems in their caregiving. One in five said that they "sometimes" or "frequently" had to deal with verbal aggression in their caregiving, 9% reported physical aggression at least "sometimes" and sexual aggression was reported by 6% of caregivers. Thirty-one percent said that those whom they cared for were at least "sometimes" uncooperative.

Caregiving Compared by Respondent Characteristics

- More caregivers resided in Adams County and Arapahoe County.
- Rates of caregiving declined with age. Men age 75 and over were less likely to feel burdened by caregiving, and men age 75 to 84 experienced more aggressive behaviors from those to whom they provided care.
- Renters and those who lived alone were less commonly caregivers, but more likely to feel burdened by their caregiving.
- Those who were limited physically felt more frequently burdened by providing care.

Current and Projected Users of Caregiver Support Services

- Persons providing care are now one of the target groups offered services by AAAs through funding provided by the National Family Caregiver Support Program (NFCSP). AAAs provide respite care to allow caregivers a much needed break. They also provide other types of support to caregivers, including caregiver training, individual counseling, information and assistance, material aid, outreach, screening/evaluation and transportation. To examine the number of

people accessing these services, the support given to caregivers was divided into two parts: respite care and "other support."

- Survey respondents were determined to "need" respite services if they had classified themselves as a caregiver and reported they needed "respite or free time for myself." If survey respondents who were caregivers stated that they needed "informal advice or emotional support," "formal advice or emotional support (from a therapist, counselor, psychologist or doctor) – on issues such as caring for grandchildren and other caregiving issues," "services or information on services (such as babysitting, supervision, benefits, transportation)," "legal assistance" or "equipment (such as toys, clothing, etc.)" they were classified as needing "other support."
- According to the survey, 24,458 older adults in the Denver-metro region were caregivers who could use respite services. The number of older adults currently estimated to need the other types of caregiver support services was 11,114.

Potential Use of Caregiving Services

- Respondents were asked about the types of help they needed in their caregiving. Fifty-eight percent said that they did not need help. Seventeen percent said that they could use help with services or information on services and 11% identified financial support as a need. Also mentioned were respite (8% of respondents) and formal advice (6%).

Barriers to Receiving Caregiving Support

- Focus groups were conducted with grandparents raising grandchildren and adults caring for older adult family members. From these groups, as well as from participants of other focus groups, came information about barriers to receiving service, including trust (i.e. of in-home respite providers), the cost of providing care and challenges with scheduling. Some focus group participants described their exhaustion from managing their lives, their jobs and their role as a caregiver—sometimes it was a 24-hour a day commitment.

Health and Mental Health

- Older adults were asked to assess their overall quality of health. One in five said that their health was "excellent," 32% said it was "very good" and 30% described their health as "good." Thirteen percent selected "fair" and just 6% said their overall health was "poor." The average rating of health was 62 on the 100-point scale. This rating was slightly lower than the average rating of 64 in 1999.

Health Compared by Respondent Characteristics

- Adams County residents had the lowest ratings for quality of health (57 on the 100-point scale) and Douglas County residents rated their quality of health higher than the overall (71 versus 62).
- The highest average rating was given by men age 85 and over (71) and the lowest by women in the same age range (54).
- Residents who were Hispanic or not white reported lower quality of health (51 and 54, respectively), as did renters (52) and those with less education (54).
- Those living alone reported health ratings slightly lower than the region as a whole (59).
- The lowest quality of health ratings were given by older adults in the lowest income range (46) and those with a condition that limited them physically (40).

Health-related Activities

- Eighty-seven percent of respondents reported engaging in moderate physical activity at least one day per week. One-quarter reported exercising moderately every day of the week. Overall, respondents exercised an average of 4 days per week.
- Nearly all respondents (95%) reported having someone they thought of as their doctor or health care provider. Of those who had a doctor or health care provider, 93% had visited that provider in the prior 12 months.
- The majority of respondents (79%) had a physical exam in the past year. About two-thirds of respondents reported having had an eye exam or a dental exam in the last year, and about one-quarter had a hearing exam.

Potential Problems Related to Health and Mental Health

- Only two percent of respondents did not identify being covered by at least one of four types of insurance. Private insurance and Medicare were the most commonly identified sources of insurance coverage, with each being cited by about three-quarters of respondents. Thirty-one percent said they were covered by another type of insurance, and 15% were covered by Medicaid.
- Twenty-four percent of respondents said that feeling depressed had been at least a "minor" problem for them in the previous 12 months, and 20% said that loneliness, sadness or isolation had been at least a "minor" problem.
- About three in ten respondents said that they had a condition that substantially limited their daily activities, 17% reported significant hearing loss, 8% were blind or had severe vision impairment and 3% said that they had an emotional or mental illness that limited their daily activities.
- While the majority of respondents (89%) had not had a fall that required medical attention in the previous 12 months, about one in ten reported at least one such fall in the past year. One percent had fallen and required medical attention three to five times.
- The percentage of older adults reporting one or two serious falls in the past 12 months increased from 1999 to 2004 (from 5% of respondents in 1999 to 10% of respondents in 2004).
- About one in five respondents had spent at least one day in the hospital in the previous 12 months, 1% had spent time in a nursing home and 4% spent one day or more in a rehabilitation facility. The average number of days that older adults had spent in a hospital in the past 12 months was 1.4, 1.0 days in a nursing home and 1.1 in a rehabilitation facility. The frequency of days spent in facilities in 2004 was similar to 1999, as were the average numbers of days.

Potential Use of Health Services

- Survey respondents were asked whether they had recently needed, but could not afford seven health-related items. Prescription medications and eyeglasses were the most commonly cited, with 8% and 7% saying that they recently had needed those items, but were not able to afford them. Five percent of respondents had been unable to afford dentures and 4% had needed a hearing aid which they could not afford. Walkers, wheelchairs and canes were each mentioned by 1% of respondents.

Barriers to Receiving Health and Mental Health Support

- Although many concerns raised by focus group participants may not have been directly related to AAA services, insight into the challenges can offer valuable learning. As one older adult explained, "If you can't get to the doctor, then you can't get sick." Accessibility to healthcare was one barrier. Others included issues with affordability, availability, citizenship, discrimination, intimidation, knowledge and understanding, legal rights of partners, mental health and transportation.

In-home Support

- Older adults were given a list of daily and household activities and asked about the extent to which they could do each item. At least half of respondents could do each item "without any help." The activities with which respondents had the greatest difficulty were those which required more physical exertion, including doing interior or exterior repairs (22% responded "cannot do this at all"); doing heavy housework like moving furniture, or washing windows (22%) and doing yard work and snow shoveling (25%). Nearly all respondents were able to use a telephone, eat or use the toilet.

Difficulty with Activities Compared by Respondent Characteristics

- Difficulty with daily and household activities tended to increase with age, often more dramatically for women. For the three activities that generally were the most difficult (doing interior or exterior repairs; doing heavy housework like moving furniture, or washing windows or doing yard work and snow shoveling), about three-quarters of women age 85 or older needed at least some help.
- In general, Hispanic and respondents who were not white needed more help with daily and household activities.
- More help with daily and household activities was also needed by renters, those living alone, with lower income and with less education.
- Respondents with a condition that limited them physically had greater problems with most activities, including the same three activities that generally were more difficult for all respondents (doing interior or exterior repairs; doing heavy housework like moving furniture, or washing windows or doing yard work and snow shoveling), but at greater rates.

Current and Projected Users of In-home Support Services

- In-home support services offered by the DRCOG AAA examined for this study included homemaking, chores and personal care. Homemaker services are assistance to persons with the inability to perform one or more of the following instrumental activities of daily living (IADL): preparing meals, shopping for personal items, managing money, using the telephone or doing light housework. Chore services include providing assistance to persons having difficulty with one or more of the following IADLs: heavy housework, yard work or sidewalk maintenance. Chore services can include "handyman" installation of items to help a person remain in their home, such as grab bars. Personal care includes the provision of personal assistance, stand-by assistance, supervision or cues for persons with the inability to perform with one or more of the following activities of daily living (ADLs): eating, dressing, bathing, toileting, transferring in and out of bed/chair or walking. If survey respondents indicated they could not do, or could do with help any of the mentioned activities, and they said they received "little" or "no" practical support, they were classified as needing these services.

- About 275 older adults in the metro-Denver region utilized the DRCOG AAA service of homemaking. The need as identified through the survey, however, was much greater; about 4,442 could have used such a service. By 2020, 529 older adults would use the AAA homemaker service if utilization rates stay constant, while 8,536 older adults would need such a service.
- Personal care services as provided by the DRCOG AAA were infrequently utilized in 2003; 95 older adults did so in 2003, which represented 0.33 persons per 1,000 population. As identified through the survey, about 2,106 older adults needed such a service. If current utilization patterns continued, 183 older adults would be provided personal care services by the DRCOG AAA in 2020, while over 4,000 would need such services.
- Chore services were needed by more older adults as identified through the survey than were homemaker or personal care services; almost 20,000 older adults were estimated to need such a service, while 529 older adults received a chore service through the DRCOG AAA in 2003. If current patterns stay constant, over 1,000 older adults would receive chore services through DRCOG in 2020, while over 38,000 would need such a service.

Barriers to Receiving In-home Support

- Focus groups investigated the barriers to receiving in-home support. Affording in-home support services was a barrier as was availability and fearing that workers could not be trusted in their homes. Often, general awareness of services at low or no cost was an issue. Focus group participants also identified needs specific to particular groups (i.e. blind or vision impaired older adults). Grandparents raising their grandchildren identified the greatest needs: as one grandparent said, "I do everything on my own."

Nutrition and Food Security

- About nine in ten survey respondents reported eating two or more complete meals a day.
- Six percent of respondents reported having needed "some" or "a lot" of help getting enough food or the right kinds of food to eat in the previous 30 days.
- One in ten respondents said that they "sometimes" or "frequently" had not been able to afford the kinds of food they wanted to eat in the previous 30-day period, 6% said that had at least "sometimes" not been able to afford to eat healthier meals, and 4% had not been able to afford enough food to eat.
- Nearly one in ten older adults (8%) reported having lost ten or more pounds in the previous six months without intending to.

Nutrition and Food Security Compared by Respondent Characteristics

- Women tended to have more difficulty with the array of nutrition and food security topics, with one in five women age 85 or older having needed help in the two months prior to the survey to get enough food or the right kinds of food.
- Greater percentages of Hispanics as well as respondents who were not white or had a lower income needed help with nutrition and food security.
- Those with less education or who were limited physically tended to respond with greater need regarding these issues.

Current and Projected Users of Nutrition and Food Security Services

- Congregate meals are provided at a nutrition site, senior center or some other congregate setting, while home-delivered meals are provided in the client's home. Respondents were classified as needing a meal if they reported needing "some" or "a lot of" help getting enough or the right kinds of food to eat, or had a "minor" or "major problem" in the past 12 months with "having enough food to eat," or reported that they "sometimes" or "frequently" were not able to afford enough food to eat or the kinds of food they wanted to eat, or healthier meals, or reported that meal preparation was something they "cannot do at all" or "could do with help" or reported that they do not eat two or more complete meals a day. To determine whether they needed a congregate meal versus a home-delivered meal, a survey respondent was classified as "homebound" if they needed help with two or more activities of daily living (ADLs) or if they said they could not use available transportation.
- In 2003, 4,165 older adults received at least one meal in a congregate setting and 2,498 received a home-delivered meal. The total number of meals supplied was 186,611 in a congregate setting and 423,620 home-delivered meals. If current utilization patterns hold steady, 8,004 persons will receive congregate meals and 4,801 will receive home-delivered meals in 2020; these recipients will eat about 800,000 home-delivered meals and 350,000 congregate meals.
- The survey identified an even larger need for meals. The total number of persons estimated to need a congregate meal was 60,016 and the number needing a home-delivered meal was 10,720. The total number of congregate or home-delivered meals needed was 4.5 million. By 2020, this need would grow to nearly 136,000 older adults needing over 8.6 million congregate or home-delivered meals.

Barriers to Receiving Nutrition and Food Security Support

- Barriers to nutrition and food security were noted in the focus group discussions. Some older adults often have had to choose between food and medication because they have felt unable to afford both, "You either eat or take your medication." Availability was an issue for some rural residents. Discrimination at congregate meal sites was at times perceived as a barrier for grandparents raising grandchildren and GLBT older adults. Transportation and the quality of food (i.e. at congregate meals sites) were also cited as barriers.

Transportation

- In response to a question about how they traveled for most of their local trips, 94% of respondents reported driving or riding in a car. Though utilized by no more than 3% of respondents, the next most common modes reported were public transportation (3%) and a senior van, shuttle or minibus (2%). The results of the 2004 survey were nearly identical to those of the 1999 survey.

Potential Problems Related to Transportation

- About one in ten had needed "some" or "a lot" of help getting or arranging transportation in the previous 12 months. Eighty-nine percent had needed no help.

Difficulty with Transportation Compared by Respondent Characteristics

- A greater percentage of older adults in Denver than in other counties had needed at least "some" help with transportation planning in the previous 12 months.
- For women, help getting or arranging transportation increased dramatically with age.
- Respondents who were Hispanic or not white needed more transportation-related help.

- Renters and those living alone needed more help, as did those with a smaller household income, less education and respondents who reported a condition that limited them physically.

Frequency of Difficulty with Transportation

- Respondents also were asked about the frequency with which they had difficulty arranging transportation for specific types of activities. About nine in ten respondents had "never" had difficulty arranging any of the four types of transportation. Six to eight percent of older adults reported "sometimes" or "frequently" needing help arranging transportation for shopping, medical trips, personal errands or recreational or social trips.

Current and Projected Users of Transportation Services

- AAAs provide older adults a means of going from one location to another. Regular transportation services are curb-to-curb, while assisted transportation includes provision of assistance, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation. A unit of service is defined as a one-way trip. Older adult survey respondents were categorized as needing the service if they had a "minor" or "major problem" in the past 12 months with having inadequate transportation, needed "some" or "a lot" of help getting or arranging transportation, or reported that it was "frequently" or "sometimes" difficult to arrange transportation, or said they "can use with help" or "cannot use at all" available transportation, or reported they have trouble getting transportation because they "have to rely on others" or "have trouble getting around without someone to help," or reported that for most local trips they do not leave the house because they do not have transportation. Survey respondents were then classified as needing assisted transportation if they reported they "cannot do" or "can do with help" "getting in and out of bed or a chair" or "walking;" otherwise they were classified as needing regular transportation services.
- DRCOG AAA transportation services were used by 6,487 older adults in 2003, or about 22 of every 1,000 older adults. They were estimated to be needed by 56,479 older adults in the region, or 193 per 1,000 population. The need is projected to grow to over 100,000 older adults by 2020.
- Assisted transportation services, which were provided in only 5 of the 16 AAAs in the state of Colorado in 2003, were not provided by the DRCOG AAA. Assisted transportation was estimated to be needed by over 17,000 older adults; by 2020, over 33,000 older adults would need such a service.

Potential Use of Transportation Services

- Older adults were asked to give unprompted responses regarding the reasons they had trouble getting necessary transportation. Forty-three percent said that car trouble was the source of their transportation problems, 14% said that having to rely on others made getting transportation difficult and another 13% said that transportation was not available when they needed it. The reasons for trouble with getting transportation varied between 1999 and 2004.

Barriers to Receiving Transportation Support

- Focus group participants noted a number of issues related to transportation. High gas prices and car maintenance were among affordability issues. Availability of transportation in rural areas, on weekends and for persons with disabilities, was a concern as well. Often transportation concerns led to difficulty accessing other services including health and mental health care and nutritional and food security services.

A Population at High Risk

- If older adults reported that they could not at all do one or more of the activities of daily living or that they required some help to accomplish them, the conclusion was that these older adults were at some risk of institutionalization. Older adults with fewer financial resources were at even greater risk because they generally could not afford to purchase the assistance needed to remain independent.
- Overall, 2% older adults were at risk for institutionalization in the region. When considering only the respondents of low- to moderate-income (under $30,000), the proportion was approximately 5%.

Institutionalization Risk Compared by Respondent Characteristics

- Broomfield County had a higher percentage of low- to moderate- income respondents at risk, while Douglas County and Gilpin County had a smaller proportion of older adults at risk of institutionalization.
- Generally, women were at higher risk of institutionalization and their risk increased with age. Men age 85 and older of low- or moderate-income had the lowest risk of institutionalization.
- Hispanics and respondents who were not white were slightly more likely to be at risk.
- Renters were more likely than homeowners to be at risk of institutional placement.
- Those with lower income or less education had higher risk.
- Those limited physically were significantly more likely to be at risk.

The Strengths of Older Adults

Quality of Life and Wellbeing

- Survey respondents rated their overall quality of life using a scale of "very good" to "very bad." Forty-three percent described their quality of life as "very good" and 45% said it was "good." About one in ten (8%) said that their quality of life was "neither good nor bad," 3% said it was "bad" and only 1% selected "very bad" to describe their quality of life. The average quality of life rating of 82 on the 100-point scale (where 100 equals "very good" and 0 equals "very bad") for the DRCOG region in 2004 was identical to the 1999 DRCOG average rating.

Quality of Life Compared by Respondent Characteristics

- Residents of Douglas County reported the highest quality of life in the DRCOG region (89 on the 100-point scale) and Adams County residents had the lowest average rating for quality of life (79).
- The oldest males (age 85 or older) reported higher quality of life ratings (86 on the 100-point scale) than males age 60 to 84 and females of all ages, with the oldest females having the lowest quality of life rating (78). Hispanics and respondents who were not white had lower average quality of life ratings, as did renters (74) and those who lived alone (78).
- Those with the lowest income, less education and those who reported having a condition which was limiting physically all gave lower overall quality of life ratings (68, 76 and 74, respectively).

Emotional Wellbeing and Outlook on Life

- Survey respondents were asked about the extent to which they agreed or disagreed with a series of statements about their perspectives on life and their relationships with others. At least eight in ten respondents "somewhat" or "strongly" agreed with each statement. The greatest agreement was with the statement "I take responsibility for my own actions" (with 100% of respondents "somewhat" or "strongly" agreeing) and "I am generally a happy person" (98%). Least agreed with was "My family and friends rely on me" (84% of respondents). The percentage of agreement between 1999 and 2004 was similar across most questions.

Practical and Social Support

- Respondents were asked the amount of practical and social support they received from different sources. About four in five respondents said that they received at least "a little" practical support from their families, with 49% saying that they received "a lot" of practical support from family. Thirty percent reported receiving "a lot" of practical support from friends, 18% from neighbors, 18% from a church or spiritual group and 9% from a club or social group. The percent of respondents receiving at least "a little" practical support from family in 2004 was similar to the 1999 survey, and a smaller percentage of respondents were receiving practical support from friends in 2004.
- The amount of social support received by older adults was generally higher than the amount of practical support reported. Over two-thirds (71%) said they received "a lot" of social support from family and half said they received "a lot" from friends. Neighbors and a church or spiritual group each were cited as providing "a lot" of social support by about one-quarter of respondents. Just 5% said they were receiving "a lot" of social support from a non-profit or community agency. As with practical support, family remained a similar source of social support in 2004. Respondents reported less support from their friends, churches or spiritual groups and clubs or social groups in 2004 than in 1999.

Productive Activities of Older Adults

- Participation in a set of key activities was considered. Overall, 22% of respondents identified themselves as caregivers, 23% were employed at least part-time and 39% said that they volunteered at least one hour per week. Six in ten respondents participated in at least one of these activities.

Activities Compared by Respondent Characteristics

- A greater proportion of Clear Creek residents were volunteers. Larger percentages of Gilpin and Clear Creek residents were employed, while Denver had a smaller percentage of older adult residents reporting at least part-time employment.
- Men and women reported similar caregiving rates.
- Respondents who were Hispanic or not white were less likely to volunteer or be employed, and Hispanics were more likely to be caregivers.
- Homeowners and those living with others had greater participation in volunteering, employment and caregiving.
- Participation in each activity increased with income.
- Those with less education and those limited physically were less likely to volunteer and to be employed, but equally likely as others to be caregivers.

Time Spent in Productive Activities

- Information on the hours spent on a longer list of productive activities was captured by the survey, too. At least nine in ten respondents reported spending one hour or more visiting with family members in person or on the phone, visiting with friends in person or on the phone or doing housework or home maintenance. The fewest respondents spent time working for pay (one hour or more per week reported by 24% of respondents) or participating in senior center activities (23% of respondents). Few changes were reported between 1999 and 2004 in the percent of respondents spending at least one hour on an activity.

Model for Aging Well

- This study builds on previous models that associated strengths with aging well using survey data collected from older adults across the State of Colorado.
- The model for aging well consists of 12 strengths which were grouped into three thematic categories: physical health, outlook on life and one's connection to others and the community.

Validity of the Model

- Older adults who possessed a greater number of strengths gave higher self-ratings of quality of life. Those with four or fewer strengths had an average quality of life rating of 63, while those with nine or more strengths gave an average rating of 90 on the 100-point scale.
- Survey respondents with fewer strengths also gave lower quality of health ratings. The average rating of health for those with nine or more strengths was 73 on the 100-point scale and 37 for those with four or fewer strengths.
- Those with the fewest strengths were at least twice as likely as those with the most strengths to have spent at least one day or more in the last year in a hospital, a nursing home or a rehabilitation facility, or to have had at least one serious fall in the previous 12 months.

- While the majority of survey respondents met the description of (rather than an institutional setting), those with more strengths were slightly more likely than those with the fewest strengths to be living in the community.

Strengths of Older Adults in the DRCOG Region

- Just under half of those responding to the survey had nine or more strengths from the categories of physical health, outlook on life and connection. Another 43% had five to eight strengths and 11% reported four or fewer strengths. The overall prevalence of each individual strength among DRCOG older adults ranged from 45% to 90%.

Strengths Compared by Respondent Characteristics

- Residents of Gilpin, Douglas, Broomfield and Clear Creek were found to have more strengths than older adults in other counties.
- Whites and those who were not Hispanic tended to have a greater number of strengths.
- Renters were three times as likely as homeowners to have only zero to four strengths.
- Those who lived with others were more likely to have nine or more strengths.
- The number of strengths generally increased with income and education.
- Those who were limited physically were less likely to possess nine or more strengths.

Economic Profiles and Projections

Economics of Service Provision

- The Social Asset Management System (SAMS) and the Final Expenditure Reports based on the Aging Services Form 480 (AAS480) were used to determine a cost per unit of selected services provided by the DRCOG AAA. Costs per unit of service provided were estimated for seven service categories (congregate meals, home-delivered meals, transportation, homemaker, personal care, adult day care, legal assistance). Costs in 2004 and the future were calculated by projecting the number of units of service to be used in the future assuming a constant rate of services provided per 1,000 persons aged 60 and older and assuming inflation to be 2.5% per year.
- For eight additional service categories (caregiver respite, caregiver non-respite support, individual counseling, material aid, chore, counseling, health promotion and outreach), the total cost to provide the service in 2003 was used to estimate 2004 and future costs by projecting an increase in growth equivalent to the growth in the older adult population and assuming inflation to be 2.5% per year.
- The combination of the increasing number of older adults and the expected rise in the cost of delivering services was projected to increase the cost of service provision about 154% from 2004 to the year 2020. For the 15 service categories for which costs were estimated, the total was projected to grow from about $8.5 million in 2004 to about $21.6 million in 2012 representing annual growth rate of about 6% (compounded annually).
- The cost of providing home-delivered and congregate meals would grow from the current amount of about $4 million to about $10 million in 2020. The cost of providing transportation services would increase from $1.6 million currently to about $4 million in 2020.
- While the survey did not include questions to estimate unmet need for each of the services for which costs per unit of service provided could be determined from SAMS and the AAS480 reports, six AAA services for which costs per unit and units per client could be determined were mapped to survey questions (congregate meals, home-delivered meals, transportation, homemaker, personal care and legal assistance).
- If the DRCOG AAA expanded its services to meet all the need identified from the survey, the cost to meet the need for each of the six services for which cost estimates could be made would be $55 million in 2004 and would grow to about $158 million by 2020. If the utilization rates stayed constant at current levels, the cost to meet the same amount of current demand for just these six services would be $6 million in 2004 and would grow to $15 million in 2020.

Cost of Providing Home- and Community-based Services versus Cost of Institutionalization

- "Long-term care" refers to the services needed by persons with physical or mental impairments who never could or no longer can function independently. The setting for these services can be nursing homes, assisted living residences, community centers or private homes. The types of services provided can include nursing care, personal care, habilitation and rehabilitation, adult day services, care management, social services, transportation and assistive technology (Nawrocki & Gregory, 2000).
- A recent survey conducted by AARP of its Colorado membership found that 88% felt it was "very" or "somewhat important" to be able to stay at home if they were to become ill or disabled (American Association of Retired Persons, 2002). This finding is consistent with most studies about the preferences of older adults. Almost all (95%) of the chronically disabled elderly living at home in 1982 said they would prefer to stay out of a nursing home as long as possible. Of those responding to a 1988 Harris poll, 87% favored a federal long-term home care program for chronically ill and disabled elderly (Wiener & Hanley, 1992).
- An analysis was performed to compare the costs of institutionalization to the costs of providing services to help keep older adults in their homes. Several assumptions were made for this analysis. The critical services viewed as necessary to keep a frail older adult in the community were: 1) personal care, 2) home-delivered meals, 3) homemaker services and 4) a life-line service (medical emergency alert). The last of these may not be reimbursed by AAAs, but the average monthly cost was included in the cost estimates. Three scenarios were created:
  - **Scenario A: Minimal support network:** The older adult was assumed to live alone with little or no support from family or friends. The services assumed to be needed were: a medical alert system, one home-delivered meal per day, one personal care visit per day and two homemaker visits per month. The monthly cost for this scenario was $2,582.
  - **Scenario B: Moderate support network:** The older adult was assumed to live alone, but to have some practical support from family or friends. The services assumed to be needed were: a medical alert system, a home-delivered meal every other day, a personal care visit every other day and a homemaker visit one time per month. The monthly cost for this scenario was $1,306.
  - **Scenario C: Heavy family involvement:** The older adult was assumed to live with family members who provided support to the older adult. It was assumed respite care would be needed by the caregiving family members. The services assumed to be needed were: respite care once a week and other caregiver support twice a month. The monthly cost for this scenario was $287.
- These costs compared to an average monthly cost of a nursing home stay in Colorado of $4,375 and the average monthly Medicaid per diem reimbursement of $3,770.
- Thus, even if AAA services serve only to delay entry into a nursing home for several months, cost savings may be accumulated. However, if the DRCOG AAA and the other AAAs in Colorado want to make keeping frail elders out of institutions one of their key goals, they should consider expanding personal care and homemaker services. Presently, about 2,498 homebound clients in the DRCOG AAA region received home-delivered meals. At most, only about one in six of these individuals received either personal care or homemaker services through the

DRCOG AAA. There is a significant difference in Medicaid and AAA levels of provision of in-home support services. This may be due to the fact that AAA funding has tended to be targeted to certain types of services such as meals and transportation, while Medicaid funding for older adults has been targeted toward lower income persons with medical needs or activities of daily living (ADL) impairments.

Contributions of Older Adults to the Economy

- A number of questions on the survey asked about the activities in which older adults engage. Survey respondents were asked about caregiving, providing help to friends and relatives, contributions of volunteer time and working for pay.
- The amount earned by older adults in the metro Denver area annually through paid wages was estimated to be about $1.48 billion.
- In addition to their paid work, older adults contributed to the community in a variety of other ways. Just under 40% participated in some kind of volunteer work; of these, the average number of hours per week volunteered is 3.3 hours. Almost two-thirds provided help to their friends or relatives, on average giving 2.6 hours per week. Others provided care to members of their family or to friends or neighbors. Of these caregivers, the average number of hours per week spent providing care ranged from 9 to 16 hours per week. The value of these unpaid contributions by older adults in the Denver region was almost $1 billion ($985,773,706) in a 12-month period.

Common Sources of Information for Older Adults

- Older adults were asked about how often they used different information sources. Eighty-nine percent of survey respondents reported that they "sometimes" or "frequently" received information about services and activities from television, 87% from the newspaper and 87% from "word of mouth." The radio was used at least "sometimes" by about two-thirds of respondents, senior publications by 62% and the library by 57%. Nearly half of respondents reported using the Internet at least some of the time.
- An interesting difference between responses in 1999 and in 2004 was regarding use of the Internet. The percent of respondents using the Internet at least "sometimes" for information about services and activities available to them jumped from 19% of respondents in 1999 to 44% in 2004.

Older Adults on the Way: The Baby Boom Generation

- The coming wave of Baby Boomers into the older adult population has planning and policy implications for organizations that support older adults.
- This component of the study included a phone survey of Baby Boomers, asking them about many of the same issues inquired of older adults.

Problems Expected in Retirement by Baby Boomers

- While older adults were asked about the extent to which each in a series of problems facing older adults was a problem for them, Baby Boomers were asked about the extent to which they anticipated facing these problems in retirement. In general, Boomers expressed greater concern about each potential problem in their future than older adults reported experiencing. Among the greatest discrepancies between the results of the two surveys was Boomers being nine times more likely to believe that being a victim of a crime would be a problem for them in retirement than older adults reported it as a problem.

Quality of Life of Baby Boomers

- Thirty-eight percent of Baby Boomers said that their overall quality of life was "very good" and 50% said it was "good." One in nine described their overall quality of life as "neither good nor bad" and about 2% said it was "bad" or "very bad." Baby Boomers' average quality of life ratings were similar to older adults in the DRCOG region in 2004 and 1999.
- The survey inquired about possible experiences in the lives of Baby Boomers, including "having a spouse or partner die" (experienced by 58% of respondents), "surviving a major illness" (41%), "having your last child move out of the house" (33%), "becoming responsible for the care of a parent" (30%), "getting a divorce" (28%), "losing your job" (26%) or "having a parent die" (10%).

Baby Boomer Perspectives on Retirement and Retirement Savings

- Among a series of statements about retirement and growing older with which respondents could agree or disagree, about two-thirds agreed that "A family's emotional support is essential during one's retirement" or "You expect to be living with a spouse or partner for most of your retirement years." One-quarter or less agreed that "The idea of growing old is frightening to you" or "You expect to have an aging parent or parent-in-law living in your home at some time during your retirement."
- Respondents expected age of retirement years was gauged. Three in ten respondents said that they thought they would retire before age 65 and another 29% predicted age 65 to be their age of retirement. Twenty-two percent thought retirement would come between age 66 and 74 and 9% expected to be 75 or older when retiring. The final one in ten believed that they would never retire. The average expected age of retirement was 66.
- Boomers were asked about their satisfaction with the amount of money they are putting aside for retirement. About one in ten were "completely" satisfied and 47% said that they were "somewhat" satisfied with their retirement savings. Twelve percent of respondents said that they were "not very" satisfied with the amount they were saving and three in ten were "not at all" satisfied.

Baby Boomers Health and Insurance Coverage

- As on the older adults survey, Baby Boomers were asked about their overall quality of health. About one-quarter said that their health was "excellent," 39% said it was "very good" and 25% described their health as "good." "Fair" was chosen by 9% of respondents to describe their overall health and "poor" by 3%. Baby Boomers' average health rating was higher than that of older adults (68 versus 62 on the 100-point scale).
- Boomers were asked about the number of days per week that they engaged in moderate physical activity. Ninety-five percent said that they exercised moderately at least one day a week. While a greater percentage of Baby Boomers reported exercising at least one day a week (95% of Baby Boomers versus 87% of older adults), a larger proportion of older adults said that they exercised seven days a week (26% vs. 15%).
- Baby Boomers were asked whether they were covered by any form of health insurance and, separately, whether they had long term care insurance. Eighty-five percent of the Boomers reported having health insurance and about one-third had long term care insurance. Baby Boomers in the DRCOG region had a lower rate of being insured when compared to older adults (85% versus 98%).

Caregiving and Baby Boomers

- About four in ten Boomers said they had children or grandchildren under age 18 living with them. Seventeen percent of Baby Boomers in the DRCOG region reported having no parents or in-laws still living and 31% said that three or more were still alive.
- The percentage of Baby Boomers saying that they provided regular care for one or more individuals was similar to older adults (18% of Baby Boomers versus 22% of older adults).
- Of the Baby Boomers who said they provided care, 31% were caregivers to a single person, 30% were providing care to two family members or friends and 39% identified three or more individuals for whom they were providing care. The average number of caregiving recipients was 2.3.

Baby Boomers Caregiving Compared to Older Adults Caregiving

- Older adults were more likely than Baby Boomers to be caring for one person.
- Baby Boomers were asked for whom they provided care. Children were the most frequently mentioned category, identified by 39% of caregivers. Parents were the next most commonly mentioned category (32% of respondents).
- Among the categories of caregiving recipients, Baby Boomers reported caring for the greatest number of children, on average (2.3).
- Those caring for children reported the highest average number of caregiving hours (22.3 hours per week), followed by those caring for parents (14.9 hours).

Potential Problems for Baby Boomers Related to Caregiving

- About one in five caregiving Baby Boomers said that they "frequently" had felt burdened by caregiving in the last two months, 40% had "sometimes" had felt burdened and 42% said they had "never" felt burdened in that period of time. A greater proportion of Baby Boomers than older adults had felt "sometimes" or "frequently" burdened by caregiving in the last two months (58% of Baby Boomers versus 38% of older adults).

Common Sources of Information for Baby Boomers

- Each potential source of information presented to Baby Boomers was used at least "sometimes" by a majority of respondents. All sources but the library were used by at least four in five Baby Boomers. Baby Boomers and older adults reported using information sources similarly. However, significantly more Boomers used the Internet at least "sometimes" (79% of Boomers versus 44% of older adults). A greater proportion of Baby Boomers said that they used the radio as a source of information (78% versus 65%).
- Baby Boomers were also asked about the types of information that they wanted related to caregiving and retirement. Forty-one percent of survey respondents wanted information about Medicare and Medicaid, 37% wanted to know about retirement planning and 35% said that they would like information about health care.

Recommendations

The model for aging well presented three thematic categories: physical health, outlook on life and one's connection to others and the community. The recommendations below are presented within these themes. As stakeholders review and deliberate on the recommendations, consideration should be given to the way in which funds can be allocated to best address the strengths and needs of older adults throughout the region. With the older adult population in the region almost doubling by 2020, attention to the burden on existing systems will be just as crucial as building new systems that address newly identified strengths and needs.

Recommendations Related to Physical Health

The strengths category of physical health is comprised of several individual strengths, including: physical activity, nutrition and food security, activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The maintenance of good health is of key importance in allowing older adults to age well.

- Recommendation #1: Continue health promotion, education and awareness campaigns to help older adults maintain a good quality of life and support such activities geared to Baby Boomers as they prepare for older adulthood.
- Recommendation #2: Further investigate the physical health disparities that exist among various segments of the population and implement new strategies for services that meet the needs of these older adults. Allocate financial resources to address the identified issues of access, awareness, education and service provision.
- Recommendation #3: Consider the cultural challenges some minority and other special populations (i.e. African American, American Indian, Asian American, Hispanic/Latino/a Americans and GLBT older adults) may face when accessing health and mental health programs and plan accordingly. Support training in cultural sensitivity, bilingual staff and other strategies to address language and cultural barriers in health-related services to diverse populations.
- Recommendation #4: Continue support for older adults with physical limitations and increase material aid to those needing such items for maintaining their independence. Continue to promote ways in which the public can accommodate older adults with vision and/or hearing impairment.
- Recommendation #5: Continue to reinforce and build upon the strengths of older adults, including attention to healthy living and participation in insurance plans. Financial planning information and education about long-term care is recommended.
- Recommendation #6: Increase awareness of congregate meal programs, home-delivered meal programs, nutrition education programs and other related resources, such as food stamps and/or food banks. Expand and adapt congregate meal programs and meal delivery programs for minority and other special populations in particular.
- Recommendation #7: Influence public policy by advocating for a more cohesive health care system that addresses the needs of older adults (including ways of making prescription drugs more affordable, requiring insurance companies to cover the cost of hearing aids and looking for opportunities to expand mental health options).

- Recommendation #8: While planning for the increased number of older adults projected to be institutionalized in the future, continue to investigate viable alternatives to institutionalization such as formal in-home healthcare services. Also offer more comprehensive support for caregivers in order to increase their ability to provide in-home healthcare to their family members.
- Recommendation #9: Improve educational outreach programs regarding health care and support healthcare providers in planning for increases in older adult utilization across the entire healthcare system (e.g. home healthcare, nursing home beds, physicians and nurses) especially in rural areas.

Recommendations Related to Outlook on Life

The category of outlook on life is comprised of mental health, personal strengths, spirituality and faith and perceptions of community value. These attributes were found as predictive for successful life outcomes for older adults in the model for aging well.

- Recommendation #1: Support efforts to educate communities on the mental health needs of older adults.
- Recommendation #2: Continue to provide opportunities for social interaction among isolated and vulnerable older adults to alleviate or reduce loneliness, depression and other mental health issues. Expand these opportunities in rural areas and provide transportation for these activities.
- Recommendation #3: Advance efforts to provide older adult services to minority and other special populations, with consideration given to unique barriers that each group might face, including: racism and homophobia; language barriers; communication/dissemination of information about services; accommodations for deaf, hard of hearing and those with vision impairment.
- Recommendation #4: Advocate for special populations, including older adult couples who, because they are gay or lesbian, lack the right to make medical decisions for their partners in the case of an emergency.
- Recommendation #5: Help reinforce and build upon the personal strengths of older adults. Continue educating older adults about ways they can protect themselves against financial exploitation and other scams. Work in partnership with community and faith-based groups to support older adults' spiritual strengths and sense of community.

Recommendations Related to Connection to Others and Community

In the model for aging well, the category of connection to others and community included results of survey questions about practical support, social support, engagement and hobbies. Included in this section are conclusions and recommendations related to caregiving, in-home support, transportation and communication.

- Recommendation #1: Find ways of expanding caregiver support programs to promote greater access and availability. Continue to provide educational and support opportunities to caregivers and advocate on their behalf. Collaborate with existing and established community groups and social service agencies; including school-based and other youth-serving programs for grandparents raising grandchildren.
- Recommendation #2: Narrow the gap between caregiver respite service use and need. Promote public awareness efforts that draw attention to in-home services available to older adults as a way of supporting those who provide care.
- Recommendation #3: In-home services for the general population of older adults should emphasize some of the more difficult chores (e.g., painting, moving furniture and snow shoveling). In rural areas, expand in-home services available to low-income older adults and find ways of getting the word out that such services are available.
- Recommendation #4: Continue to increase awareness of the public transportation options available to older adults, with particular attention to females, older adults who were not white or have lower incomes.
- Recommendation #5: Better implement transportation options that meet the needs of older adults and expand such services in rural areas and for geographically isolated older adults.
- Recommendation #6: Establish regional or community-based systems of support—service hubs— through which care is coordinated and older adults access the services they need in a more central way and with less burden on them.
- Recommendation #7: Consider implementing client-centered and client-directed care management systems for the most vulnerable, at-risk older adults.
- Recommendation #8: Diversify and expand outreach efforts in the region.
- Recommendation #9: Improve communication with the State and with service providers.
- Recommendation #10: Make marketing campaigns creative and easily recognizable. Dedicate resources to ensure that older adults become familiar over time with the design and message.
- Recommendation #11: Encourage older adults to build and maintain their connections with family, friends and community for practical and social support. Promote older adult engagement and hobbies. Applaud the strengths of caregivers.

References

Alecxih, L. M. B., Lutzky, S., Corea, J., & Coleman, B. (1996). *Estimated cost savings from the use of home and community-based alternatives to nursing facility care in three states*. Washington, DC: American Association of Retired Persons, Public Policy Institute.

American Association of Retired Persons. (2002). *2002 AARP Colorado Member Opinion Survey: Long-Term Care*: AARP.

Balkovic, B., & Hartzok, J. (2004, April). Individual Income Tax Returns, Preliminary Data, 2002. *SOI Bulletin, Winter 2003-2004*.

Boulder County Aging Services Divison. (2004). *Services for Older Adults in Boulder County: Trends in Needs, Programs, and Local Funding*. Boulder.

Centers for Disease Control and Prevention. (2004). *Healthy Aging: Preventing Disease and Improving Quality of Life Among Older Americans 2004*. Atlanta, GA.

Chernoff, R. (2001). Nutrition and Health Promotion in Older Adults. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences, 56*, 47-53.

Colorado Department of Revenue. (2004). *Income Tax - Colorado Tax Rates*. Retrieved August 9, 2004, from http://www.revenue.state.co.us/taxstatutesregs/incomeindex/taxrateswhatarethey.html

Colorado Fiscal Policy Institute. (2004). *The Self-Sufficiency Standard for Colorado 2004: A Family Needs Budget*.

Denver Regional Council of Governments. (2004). *Programs Funded by the Denver Regional Council of Governments to Serve Older Adults in 2004*.

Doty, P. (2000). *Cost-Effectiveness of Home and Community-Based Long-Term Care Services*: U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy.

Dychtwald, K. P. D. (1999). *Age Power: How the 21st Century Will Be Ruled By The New Old*. New York: Jeremy P. Tarcher/Penguin Putnam, Inc.

Friedland, R. B., Ph.D. , Summer, L., M.P.H., & Expert Working Group. (1999). *Demography Is Not Destiny*: National Academy on an Aging Society.

Generations Policy Initiative and the Harvard Institute for Learning in Retirement. (2004). The Age Explosion: Baby Boomers and Beyond. *Harvard Generations Policy Journal, 1*, 33.

Grabowski, D. C., Feng, Z., Intrator, O., & Mor, V. (2004, June 16). *Recent Trends In State Nursing Home Payment Policies*. Retrieved August 12, 2004, from http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.363/DC1#14

Hetzel, L., & Smith, A. (2001). *The 65 Years and Over Population: 2000*: US Census Bureau.

Hodge, P. (2004). Baby Boomer Public Policy: A New Vision. *Harvard Generations Policy Journal, 1*(Winter).

Jackson, M. E., & Burwell, B. O. (1990). *Publicly-Financed Home Care for the Disabled Elderly: Who Would Be Eligible?* Washington, D.C.: U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy and SysteMetrics/McGraw-Hill.

Kingwood College Library. (2004). *American Cultural History 1920-1929*. Retrieved July 27, 2004, from http://kclibrary.nhmccd.edu/decade20.html

Kobayashi, M. M. M., Ellis, M. R., Miller, T. I. P. D., Rivera, M. V., & Grousset, R. J. (1999). *The Status of Older Adults Living in the DRCOG Region*.

Kobayashi, M. M. M., Miller, T. I. P. D., & Spence-Ellis, R. (1998). *Survey of the Strengths and Needs of Older Adults in Boulder County*. Boulder: Boulder County Aging Services.

Nawrocki, H., & Gregory, S. R. (2000). *Across The States 2000: Profiles Of Long Long-Term Care Systems*: Independent Living/Long-Term Care, Public Policy Institute: American Association of Retired Persons.

Office of the State Auditor. (2004). *State Services for Older Coloradans Department of Human Services: Performance Audit*. Denver: State of Colorado.

Osterkamp, L., MSW, PhD, & Press, A. N., PhD. (2002). *Strengths Associated With Successful Aging*. Boulder: Boulder County Aging Services Division.

Robinson, J., Shaver, P., & Wrightsman, L. (1991). *Measures of Personality and Social Psychological Attitudes*. San Diego: Academic Press Inc.

Roper ASW & AARP. (2004). *Baby Boomers Envision Retirement II: Survey of Baby Boomers' Expectations for Retirement*: AARP.

Roper Starch Worldwide Inc. & AARP. (1999). *Baby Boomers Envision Their Retirement: An AARP Segmentation Analysis*: AARP.

Rosenbloom, S. (2003). *The Mobility Needs of Older Americans: Implications for Transportation Reauthorization*.

Rowe, J. W. M. D., & Kahn, R. L. P. D. (1998). *Successful Aging*. New York: Pantheon Books.

Social Security Administration. (2004). *Tax Rate*. Retrieved August 9, 2004, from http://www.ssa.gov/cola/colafacts2003.htm

The Kiplinger Washington Editors Inc. (2004, March 1). *Average Annual Cost of Nursing-Home Care by State*. Retrieved August 12, 2004, 2004, from http://www.keepmedia.com:/Register.do?oliID=225

U.S. Department of Labor: Bureau of Labor Statistics. (2004). *Quarterly Census of Employment and Wages*. Retrieved August 5, 2004, from http://www.bls.gov/bls/wages.htm

U.S. General Accounting Office. (1994). *Medicaid and Long-term Care: Successful Efforts to Expand Home Services While Limiting Costs.* Washington, D.C.

Wiener, J. M., & Hanley, R. J. (1992). Caring for the Disabled Elderly: There's No Place Like Home. In S. M. Shortell & U. E. Reinhardt (Eds.), *Improving Health Policy and Management: Nine Critical Research Issues for the 1990's*: Foundation of the Amer College.

Wiener, J. M., & Stevenson, D. G. (1998). *Long-Term Care for the Elderly: Profiles of Thirteen States*. Washington D.C.: The Urban Institute.

Wiener, J. M., Stevenson, D. G., & Kasten, J. (2000). *State Cost Containment Initiatives for Long-Term Care Services for Older People*: Congressional Research Service: The Library of Congress.