Our Aging Neighbors: Are We Ready?

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Overview of the First Presentation

- Unprecedented Social and Demographic Changes in the U.S.
- A Few Key Indicators of Well-Being of Older Americans
- Older Residents of Rural versus Urban Areas
- Demographic Change in Oregon
- Implications and Suggestions for Action
Unprecedented Social and Demographic Changes

The older adult (65+) population is growing in size and proportion, particularly the oldest old:

• In 2012, 43.1 million, or 13.7%. of U.S. residents were 65+; by 2030, 20.3%
  • This represents a **40.7% projected increase** in the size of the 65+ population, compared to a projected growth of 12.4% in the U.S. population overall
  • The % 65+ in 2050 will be 20.9% → the aging of the U.S. population will be a sustained trend
2016 Older Americans
Key Indicators of Well-Being
INDICATOR 1: Number of Older Americans

Population age 65 and over and age 85 and over, selected years, 1900–2014, and projected years, 2020–2060

NOTE: Some data for 2020–2050 have been revised and differ from previous editions of Older Americans. Reference population: These data refer to the resident population.

INDICATOR 1: **Number of Older Americans** (continued)
Rural vs. Urban

• Rural areas in the U.S. have greater proportions of people aged 65+ and 85+
  • In 2011, 16.2% of the nonmetropolitan vs. 12.6% of the metropolitan population in the U.S. was age 65+
  • For the 85+, these figures were 2.2% of the nonmetropolitan vs. 1.7% of the metropolitan U.S. population

• 1 in 5 older adults live in rural America

Increasing Racial and Ethnic Diversity of the Older Adult Population

• In 2012, 86% of the older adult population was white non-Hispanic. In 2030, projections indicate about 72%

• Group differences in life expectancy are likely to widen due to disparities in income, education, neighborhood environments, lifetime access to health care, occupational hazards
INDICATOR 2: Racial and Ethnic Composition

Population age 65 and over, by race and Hispanic origin, 2014 and projected 2060

NOTE: The presentation of racial and ethnic composition data in this table has changed from previous editions of Older Americans. Unlike in previous editions, Hispanics are not counted in any race group. The term “non-Hispanic White alone” is used to refer to people who reported being White and no other race and who are not Hispanic. The term “non-Hispanic Black alone” is used to refer to people who reported being Black or African American and no other race and who are not Hispanic, and the term “non-Hispanic Asian alone” is used to refer to people who reported only Asian as their race and who are not Hispanic. The use of single-race populations in this chart does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. The race group “non-Hispanic, All other races alone or in combination” includes people who reported American Indian and Alaska Native alone who are not Hispanic; people who reported Native Hawaiian and Other Pacific Islander alone who are not Hispanic; and all people who reported two or more races who are not Hispanic. “Hispanic” refers to an ethnic category; Hispanics may be of any race.

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States and States: April 1, 2010, to July 1, 2014 (PEPASR6H); U.S. Census Bureau, Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060 (NP2014_D1).
Changing Family Structures

• Fewer children/smaller families
• More childlessness
• Increased divorce
• More complex families, e.g., step-children
• More nontraditional families
  • For example, LGBT elders are less likely to have children, more likely to live alone
INDICATOR 3: Marital Status

Marital status of the population age 65 and over, by sex and age group, 2015

NOTE: Married includes married, spouse present; married, spouse absent; and separated.
Reference population: These data refer to the civilian noninstitutionalized population.
INDICATOR 4: Educational Attainment

Educational attainment of the population age 65 and over, selected years, 1965–2015

NOTE: A single question that asks for the highest grade or degree completed is used to determine educational attainment. Prior to 1995, educational attainment was measured using data on years of school completed.
Reference population: These data refer to the civilian noninstitutionalized population.
INDICATOR 4: Educational Attainment (continued)

Educational attainment of the population age 65 and over, by race and Hispanic origin, 2015

- **Total**: 84% high school graduate or more, 27% bachelor's degree or more
- **Non-Hispanic White alone**: 89% high school graduate or more, 29% bachelor's degree or more
- **Black alone**: 75% high school graduate or more, 17% bachelor's degree or more
- **Asian alone**: 74% high school graduate or more, 34% bachelor's degree or more
- **Hispanic (of any race)**: 54% high school graduate or more, 12% bachelor's degree or more

**NOTE**: The term “non-Hispanic White alone” is used to refer to people who reported being White and no other race and who are not Hispanic. The term “Black alone” is used to refer to people who reported being Black or African American and no other race, and the term “Asian alone” is used to refer to people who reported only Asian as their race. The use of single-race populations in this chart does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. Reference population: These data refer to the civilian noninstitutionalized population. SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.
INDICATOR 15: Life Expectancy

Life expectancy at ages 65 and 85, by race and sex 1981–2014

NOTE: Life expectancy estimates are from annual life tables produced by the National Center for Health Statistics found at http://www.cdc.gov/nchs/products/life_tables.htm. Some estimates have been revised and may differ from previous editions of Older Americans due to changes in methodology and to the use of intercensal population estimates for 2001–2009. See Appendix II, Life Expectancy, of Health, United States, 2015 for a description of the changes in life table methodology.

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.
INDICATOR 18: Oral Health

Percentage of people age 65 and over who had dental insurance, had a dental visit in the past year, and had no natural teeth, by age group, 2014

NOTE: Dental insurance is estimated from questions on whether the respondent’s private health insurance plan covers dental care and whether the respondent has a single service plan covering dental care. Dental visits in the past year were estimated from responses to the question, “About how long has it been since you last saw or talked to a dentist?” The percentage with no natural teeth was estimated from responses to the question, “Have you lost all of your upper and lower natural (permanent) teeth?” All estimates were calculated from the sample adult component of the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.
INDICATOR 19: Respondent-Assessed Health Status

Percentage of people age 65 and over with respondent-assessed good to excellent health status, by age group and race and Hispanic origin, 2012–2014

- Total
- Non-Hispanic White
- Non-Hispanic Black
- Hispanic (of any race)

NOTE: Data are based on a 3-year average from 2012–2014. Total includes all other races not shown separately. See data sources for the definition of race and Hispanic origin in the National Health Interview Survey. Reference population: These data refer to the civilian noninstitutionalized population. SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.
INDICATOR 20: Dementia

Percentage of the non-nursing home population age 65 and over with dementia, by age group and sex, 2011

NOTE: The estimate of dementia presented here includes Alzheimer’s disease and other related dementias such as frontotemporal, Lewy body, mixed, and vascular dementia, which are often indistinguishable from Alzheimer’s disease in their presentation and outcomes.

Dementia status in the National Health and Aging Trends Study (NHATS) was determined using three types of information: (1) a report (by the respondent or proxy) that a doctor told the sample person that he or she had dementia or Alzheimer’s disease; (2) a score indicating probable dementia on a screening instrument administered to proxy respondents during the interview; and (3) cognitive tests that evaluate memory, orientation, and executive function administered to the respondent during the interview. See http://nhats.org/scripts/documents/DementiaTechnicalPaperJuly_2_4_2013_10_23_15.pdf for details on dementia measurements in NHATS.

Reference population: These data refer to Medicare beneficiaries not living in nursing homes.

INDICATOR 26: **Physical Activity**

Percentage of people age 65 and over who reported participating in leisure-time aerobic and muscle-strengthening activities that meet the 2008 Federal physical activity guidelines, by age group, 1998–2014

NOTE: This measure of physical activity reflects the 2008 Federal physical activity guidelines for Americans (available from: http://www.health.gov/PAGuidelines/). The 2008 Federal guidelines recommend that adults age 65 and over who are fit and have no limiting chronic conditions perform at least 150 minutes (2 hours and 30 minutes) a week of moderate-intensity, or 75 minutes (1 hour and 15 minutes) a week of vigorous-intensity aerobic physical activity or an equivalent combination of moderate- and vigorous-intensity aerobic activity. Aerobic activity should be performed in episodes of at least 10 minutes, and preferably, it should be spread throughout the week. In addition, they should perform muscle-strengthening activities that are moderate or high intensity and involve all major muscle groups on two or more days a week, because these activities provide additional health benefits. The measure shown here presents the percentage of people who fully met both the aerobic activity and muscle-strengthening guidelines, irrespective of their chronic condition status.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.
INDICATOR 28: Cigarette Smoking

Percentage of people age 65 and over who are current cigarette smokers, by sex, selected years, 1965–2014

NOTE: Questions concerning cigarette smoking differed slightly on the National Health Interview Survey across the years for which data are shown. Data starting in 1997 are not strictly comparable with data for earlier years due to the 1997 National Health Interview Survey (NHIS) questionnaire redesign. For details, see Health, United States, 2015, Appendix II.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.
INDICATOR 36: Residential Services

Percentage distribution of Medicare beneficiaries age 65 and over residing in selected residential settings, by age group, 2013

NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, or help with medications. Respondents were asked about access to these services, but not whether they actually used the services. A residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a non-family, paid caregiver.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.
INDICATOR 41: Transportation

Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who made a change in transportation mode due to a health or physical problem, by type of change and age group, 2013

Reference population: These data refer to noninstitutionalized Medicare beneficiaries.
SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.
Special Feature: Informal Caregiving

Number of informal caregivers, by age group and sex, 2011

Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability.

SOURCE: National Study on Caregiving.
Special Feature: **Informal Caregiving** (page 2)

Percentage distribution of informal caregivers and number of caregiving hours provided, by relationship to care recipient, 2011

Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability.

SOURCE: National Study on Caregiving.
Special Feature: Informal Caregiving (page 4)

Percentage of informal caregivers reporting positive and negative aspects of caregiving, by level of impact, 2011

Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability. Estimates may not sum to the totals because of rounding.

SOURCE: National Study on Caregiving.
Family Caregivers

“While family caregiving is an intensely personal issue, it is critically important to the well-being of our aging U.S. population, their families and society – and must be taken seriously as a critical issue of public policy.” AARP, 9/23/16

BUT, there are fewer family members to rely on to care for a growing number of older adults. Increasingly, adult daughters (backbone of family caregiving) are in the paid workforce, and many are geographically distant

With longer life expectancies, caregivers themselves (e.g., adult children and spouse caregivers) may be living with chronic health problems and limitations in functioning

Care needs are increasingly complex and challenging (e.g., dementia)
Older Adults in Rural Areas

More likely to be married than those in urban areas (31% vs. 29%), but just as likely to be widowed (28.6%). (Data on same-sex marriages and domestic partnerships not readily available.)

Lower educational attainment (15.2% with bachelor’s or graduate or professional degree compared with 23.1% of older adults in urban areas).

Slightly higher proportion of older veterans (23.7%) compared to urban areas (22.5%).

More “traditional” outlook on social issues, may be less accepting and less trusting of government programs, more independent and self-reliant, more religious, and more politically conservative.
Older Adults in Rural Areas (cont.)

Older adults in rural areas have:
• higher rates of community-and individual-level poverty than urban areas
• less access to health care
• fewer community resources
• poorer health and fewer healthy behaviors

YET rural environments offer many opportunities and show strengths of older adults, e.g.:
• more close-knit social networks and supports, contributing to an increased sense of well-being
• greater entrepreneurship among women, especially upon widowhood, bringing both financial and social benefits
• greater self-reliance and resilience
Some Key Health-Related Issues for Older Adults in Rural Areas

• Access to health care (distance to services, transportation difficulties, insufficient numbers of providers)
• Lack of behavioral health providers
• Stigma associated with utilizing mental health services
• Higher risk for mental health issues
• Outmigration of adult children (risk of social isolation/fewer family caregivers)
The Demographics of Aging in Oregon
So, Now What?  Implications and Suggestions for Action

1. Population aging is here to stay. Identify specific community needs and preferences (physical, social, health care/services) and make a plan to address them in order to:

- maximize the health and well-being of elders
- reduce public expenditures
- make full use of elders – our only growing natural resource
Making a Plan

The **physical, social and service environments** in our communities affect older adults’ ability to stay active and healthy so they can continue to contribute economically and socially. The World Health Organization completed its global research project on what makes cities age friendly and released its Age-Friendly Cities guide in 2007. Since then, urban and rural communities alike around the world have developed action plans to become more age friendly, recognizing that these efforts benefit residents of all ages.
2. Recognize the population’s diversity (racial/ethnic/social/economic) and be inclusive.

3. Address and support the essential role of family caregivers to older adults.
Implications and Suggestions for Action (cont.)

4. Recognize that the generations are intertwined: Age-friendly communities are good for the young, old and everyone in between.
A Behavioral Health Resource

The older adult behavioral health initiative, funded through OHA, strengthens services for older adults and people with physical disabilities. The Initiative supports 24 professionals who specialize in behavioral health for older adults and people with disabilities in local and regional community mental health programs throughout Oregon.

Their purpose is to build capacity in each community’s behavioral health system to provide the type of services older adults and people with physical disabilities need.

Visit the website for more information about the program

or contact Nirmala Dhar, program coordinator:
Desk: 503-945-9715    Fax: 503-947-5546    Email: nirmala.dhar@dhsoha.state.or.us
Useful Resources

Exemplar rural age-friendly efforts:  http://www.agefriendlymanitoba.ca/

Family caregiving:

Rural aging:

U.S. data chartbook on older adults:
2016 Older Americans Key Indicators of Well-Being.  http://www.agingstats.gov/
Useful Resources (cont.)

Value proposition for age-friendly communities:
*The Case for Age-Friendly Communities.*
http://www.giaging.org/resources/the-case-for-age-friendly-communities

Information on the Portland/Multnomah County Age-Friendly Initiative:
www.agefriendlyportland.org

The WHO’s Global Age-Friendly Initiative
https://extranet.who.int/agefriendlyworld/

The WHO’s Guide to Age-Friendly Cities:
In sum, what we do now to make our communities good places to grow up and grow old will yield returns not only for today’s elders but also tomorrow’s – that is, for all of us.

Thank you for your interest!

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